2nd EDITION

FORENSIC PSYCHOLOGY

Research, Clinical Practice, and Applications

MATTHEW T. HUSS

WILEY

FORENSIC PSYCHOLOGY

RESEARCH, CLINICAL PRACTICE, AND APPLICATIONS

SECOND EDITION

MATTHEW T. HUSS

CREIGHTON UNIVERSITY

WILEY

Publisher:	George Hoffman
Acquisitions Editor:	Christopher Johnson
Assistant Editor:	Brittany Cheetham
Product Designer:	Beth Tripmacher
Marketing Manager:	Margaret Barrett
Photo Editor:	Mary Ann Price
Cover Designer:	Kenji Ngieng
Associate Production Manager:	Joyce Poh
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Cover Photo Credits:	© nullplus/iStockphoto © Syldavia/iStockphoto © Rich Legg/iStockphoto

This book was set by MPS Ltd, Chennai. Cover and text printed and bound by Edwards Brothers Malloy.

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Library of Congress Cataloging-in-Publication Data

Huss, Matthew T.
Forensic psychology : research, clinical practice, and applications / Matthew T. Huss, Creighton University. — 2nd edition.
pages cm
Includes bibliographical references and index.
ISBN 978-1-118-55413-5 (pbk.)
1. Forensic psychology. I. Title.
RA1148.H87 2014
614'.15—dc23

2013007830

Printed in the United States of America
10 9 8 7 6 5 4 3 2 1

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Preface

Forensic psychology is becoming increasingly popular both on the graduate and the undergraduate level. However, the very term *forensic psychology* is interpreted differently by scholars and the general public. Some experts in the field use it to describe the broad field of psychology and law that includes the clinical practice of psychology, correctional psychology, police psychology, and nonclinical areas of psychology and the law (e.g., jury behavior, eyewitness identification). There are several textbooks available that focus on the broader field. However, there is a lack of high-quality textbooks that focus solely on the clinical practice of forensic psychology, which is primarily exemplified in the assessment and treatment of individuals who interact with the legal system, for undergraduate students and even beginning graduate students. This textbook was designed to focus on the more narrow or traditional definition of forensic psychology—the practice of forensic clinical psychology. The second edition of this text continues to address several specific objectives in introducing this field to students.

1. The need for clinical psychologists to practice within their *scope of practice* as a forensic psychologist is emphasized. Scope of practice is defined by adhering to the empirical literature, practicing within one's expertise, and avoiding practice as a legal actor (e.g., attorney, judge, and jury) and instead practicing as a psychologist within the legal context. Throughout the text, scope of practice issues are mentioned and at times explained in great depth. Furthermore, the legal and ethical ramifications for practicing outside one's scope of practice are discussed.
2. Accordingly, the text focuses on empirically supported clinical practice and places little emphasis on aspects of forensic psychology that currently have little empirical support or are purely sensational. It is not within the scope of this text to identify the best clinical practice, but there will be emphasis on the use of research and the need for forensic psychologists to be scholar-practitioners. Part of this emphasis will be to critically evaluate aspects of clinical practice that need greater empirical support. I have attempted to further emphasize this process by including one text box in each chapter as a Focus on Research in the second edition.

3. The text also exposes students to case law and statutory law necessary in the practice of forensic psychology. Students should recognize that forensic psychologists need to be familiar with the law in a given jurisdiction in order to be useful to the courts. Significant discussion of case and statutory law also enables students to understand the role of the law in shaping forensic psychology and the lives of people impacted by forensic psychology.
4. This text encourages understanding of the law as a living and breathing entity in the practice of forensic psychology, as in its ability to be therapeutic or antitherapeutic to the people impacted by it. Though significant discussion of the term *therapeutic jurisprudence* is removed in the second edition, I still believe it is important to anchor students to the importance of the law and to suggest that the law can have negative or positive effects, depending on both its original determination and the manner in which it is applied.
5. This text tries to incorporate real-world examples that grab the attention of students. Case studies and real-world examples are a regular part of the textbook both in terms of special text boxes and integration within the text itself. This objective is especially important in a textbook focusing on the practice of clinical psychology in order to give the student some introductory semblance of the actual practice of forensic psychology. The examples have been updated in the second edition to include more recent current events.
6. This textbook is intended to be user-friendly for both students and instructors. The writing style is intended to be scholarly but engaging to students. Not only is this textbook's focus on the application of forensic psychology, but it also focuses on helping students get an accurate understanding of the necessary training/education and available employment opportunities. For the instructor, there are a limited number of primary chapters in order to make the text flexible so that instructors can choose chapters as their own interest/expertise dictates or supplement the text as they desire. The second edition has attempted to improve on this by clearly identifying chapter objectives in the beginning and then focusing on more abstract or integrative ideas in the Reflection and Review section at the end of the chapters.

The textbook is organized into five different sections. The first section of the text covers the Fundamentals of Forensic Psychology and includes three chapters. Chapter 1, What Is Forensic Psychology?, serves as the primary introductory chapter and begins to introduce the ideas that students will see throughout the textbook. Chapter 1 focuses on defining what forensic psychology is and what forensic psychology is not. The more sensational aspects of forensic psychology are mentioned along with often inaccurate media depictions. The broader field of psychology and law is referenced, but it is made clear that the primary focus of this textbook will be on the clinical practice of forensic psychology. The chapter concludes by discussing the training and education necessary to become a forensic psychologist. Chapter 2, Assessment, Treatment, and Consultation in Forensic Psychology, serves as another introductory chapter and describes clinical assessment and treatment broadly and within a forensic context. Specifically, it discusses

the unique challenges that forensic psychologists often face clinically, legally, and ethically. The term *scope of practice* is introduced and explained as it will be integrated throughout the entire text. The final chapter of this first section, Expert Testimony and the Role of the Expert, offers an introduction to the importance of the law in the practice of forensic psychology. Readers are encouraged to think about the far-reaching effects of the law, not only in terms of the practice of forensic psychology but also on the people who are directly involved in the legal system. The idea of *therapeutic jurisprudence* is introduced and will be used throughout the entire text as a theme. All of this material is organized around the widening role and potential impact of forensic experts and expert testimony.

The second section of the textbook is organized under the category of Violence and Forensic Psychology. Chapter 4 is devoted entirely to a discussion of psychopathy. Careful attention is given to the distinction between psychopathy and antisocial personality disorder. This chapter reviews the general literature focusing on psychopathy and its relevance to violence specifically. Chapter 5, Violence Risk Assessment, reviews the history of clinical and actuarial risk assessment along with the limitations of both. Specific discussion of several actuarial or structured approaches to risk assessment will be made within the context of performing risk assessment and risk management across clinical settings and situations. The final chapter of this section, Sexual Offenders, examines sexual offending against adults and children as it receives increasing attention from the media and in the scientific literature. This chapter discusses the treatment, assessment, and risk assessment of sex offenders. Special attention also is given to the different laws affecting sexual offenders such as community notification, registration laws, and sexually violent predator (SVP) laws.

The third section, Mental Health Law and Forensic Psychology, begins with Chapter 7, Civil Commitment. This chapter is the first of three that will focus on the general role of mental capacity and the idea that the law often changes in how it defines mental illness, depending on the legal issue. It defines civil commitment, describes the historical basis for it, and discusses the more recent evolution in civil commitment procedures. Specifically, outpatient commitment, psychiatric advanced directives, and coercion are examined in some depth. Chapter 8, Civil and Criminal Competence, focuses on the issues surrounding civil and criminal competency and the distinction between criminal competency and insanity. It examines the different points along the adjudication process at which competency can be raised and the relevant legal cases and measures used in clinical practice, with much of the focus on competence to stand trial. In Chapter 9, Insanity and Criminal Responsibility, the varying standards of insanity are discussed along with other relevant changes to related legal issues. The relevant clinical measures and the various myths surrounding insanity are examined in depth. Various other legal defenses involving criminal responsibility also are briefly discussed. Students are exposed to the interrelationship between of civil commitment, insanity, and competency.

In the fourth section of the textbook, Children and Family in Forensic Psychology, there are three chapters that all touch on some aspect of the family. Chapter 10, Domestic Violence and Stalking, begins by defining domestic violence and discusses the importance of critically evaluating the literature in regard to prevalence rates. The

chapter focuses on the etiology, assessment, risk assessment, and treatment of domestic violence perpetrators. The chapter discusses the psychological and social aspects of domestic violence. Chapter 11, Juvenile Delinquency and Juvenile Justice, focuses on the changing role of the juvenile courts in reaction to the public perception of juvenile crime and the realities of juvenile violence. The differences between juvenile offenders and adult offenders are examined and specific attention is given to the myths and realities surrounding school shootings. Chapter 12, Child Custody, exposes students to the legal and psychological literature involving child custody determinations. Special attention is paid to the differences between child custody evaluations and psychological evaluations, along with scope of practice issues involved in this difficult area of practice. In addition, child abuse is discussed generally and in terms of its relevance to child custody situations.

The final section of the textbook, Civil Aspects of Forensic Psychology, consists of one chapter but covers several aspects of civil law relevant to forensic practice. Chapter 13, Personal Injury and Discrimination in Civil Law, focuses on several areas of forensic psychology that are less sensational and severely understudied. Nonetheless, the area may represent the largest area of forensic practice. This chapter describes areas such as personal injury, psychological independent medical evaluations, workers' compensation claims, sexual harassment, and employment discrimination. These areas of forensic psychology are often ignored in the research but offer a unique opportunity for the practice of forensic psychology.

Several changes have been made to this second edition. The research has been updated throughout and discussion now frequently reflects changes in the developing research. For example, field reliability issues of long well-accepted techniques are mentioned in numerous chapters throughout this edition. Another discussion now addresses the evolving research regarding the measurement of psychopathy with only the PCL-R. The Focus on Research boxes highlight particular research studies in more depth at least once per chapter, Also, more information has been added about treatment-related aspects throughout the textbook to balance out some of the assessment focus. In regard to the instructor materials, the multiple-choice items have been revised, essay and short answer questions have been added, and the PowerPoint slides have been updated to reflect changes and improvements.

Acknowledgments

The number of people contributing to this edition of the book continues to grow. At a very foundational level, I would like to thank Betsy Adherhold for some of the early research and Kristen Davis for her help updating the instructor materials. I would also like to thank Alan Buttars for his meticulous editing of an initial draft. However, this edition would never have been possible without the clients and students who have provided me with examples and asked the good questions that challenge me to better communicate the information and hopefully be a better clinician. Finally, I would not be able to do any of this without the support of my wife and three daughters. They make any endeavor worthwhile. Thank all of you.

1 What Is Forensic Psychology? An Introduction

Chapter Objectives

1. Define forensic psychology and differentiate it from related fields
2. Understand the development of forensic psychology
3. Know some of the basic structure and function of the legal system
4. Begin to appreciate the importance of the law in the practice of forensic psychology
5. Identify training and professional opportunities in forensic psychology

What Is Forensic Psychology?

You have opened this book looking forward to learning something about **forensic psychology**, one of the fastest growing areas in all of psychology. But do you really know what forensic psychology is? Is it like those *Crime Scene Investigation* (*CSI*) shows on television? Does forensic psychology involve apprehending serial killers? It has to be like the movies! *Silence of the Lambs*? *Kiss the Girls*? These are the types of things forensic psychologists do, right? These images may portray limited aspects of forensic psychology that tantalize the public. However, similar examples might give inaccurate impressions of forensic psychology. Ultimately, these images get people interested in the topic and encourage us to think about the horrific things human beings are capable of at their worst. Nonetheless, forensic psychology is so much more than these sensational aspects.

I rarely tell people when I meet them that I am a forensic psychologist. I usually tell them I work at the local university. My proud father thinks my response makes it sound like I sweep the floors instead of work as a college professor. However, the images that come to mind for the average person when you state that you are a forensic psychologist are sometimes difficult to correct. In this chapter, I am initially going to spend

some time clarifying the nature and limits of forensic psychology along with offering a specific definition of forensic psychology that we will use for the remainder of the book. And don't worry; some of those images that come to mind from the movies and television are accurate. Figure 1.1 shows the seminal work of Dr. Theodore Blau, former president of the American Psychological Association (APA).

Is This Forensic Psychology?

Many people equate forensic psychology with forensic science or law enforcement. They believe that forensic psychologists arrive at a crime scene, survey the area, and

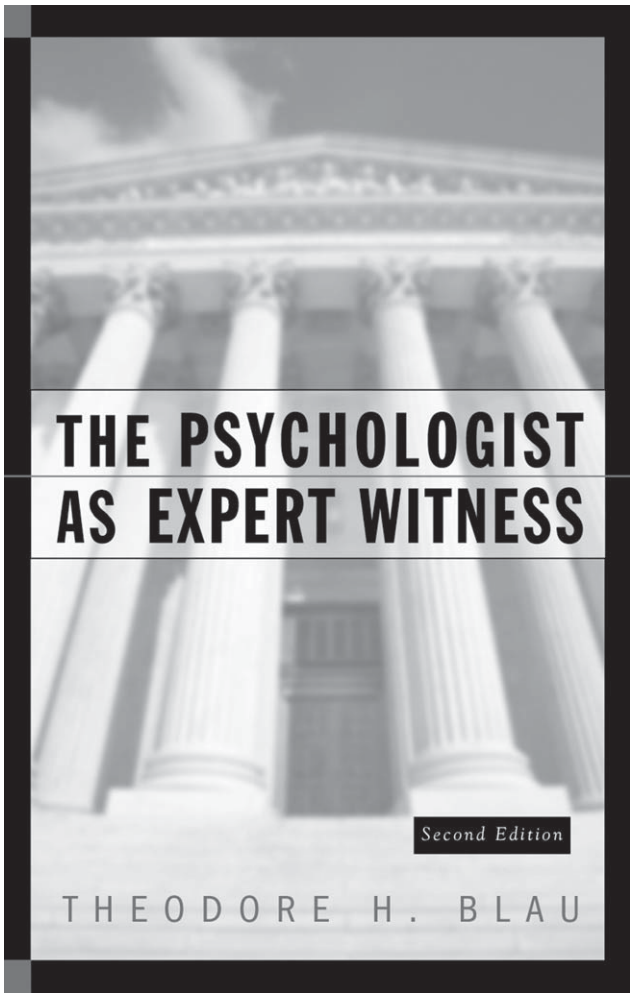

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Figure 1.1. Theodore Blau became the first independent clinical psychologist to be elected president of the American Psychological Association in 1977 and began to pursue work in forensic psychology soon thereafter. His books on forensic psychology serve as invaluable practical resources for practicing forensic psychologists to this day.

eventually identify a number of psychological clues that will help catch the criminal. You see these situations continually portrayed by television shows, in the news media, and in movies. Research suggests these media images may be leading to a number of incorrect perceptions about forensic science in general (Patry, Stinson, & Smith, 2008). In fact, as these aspects of forensic science are more routinely used in court, they are coming under increasing criticism for their poor reliability and validity (National Research Council, 2009). However, psychologists are not typically called upon to collect DNA specimens, analyze a sample of dirt left behind for the geographic location from which it originated, or even conduct so-called psychological profiles. Forensic psychologists are not biologists or chemists and are rarely crime scene investigators or law enforcement officers. It may sound odd, but they are just psychologists. They study human behavior and try to apply those principles to assist the legal system.

When an old friend of mine comes into town, I often go over to her parents' house for a barbeque. One time her father asked me, knowing that I was a forensic psychologist, "How in the heck do you do therapy with dead people?" Now, while he was at least thinking about forensic psychologists in terms of tasks that psychologists typically perform (i.e., treatment of mental illness), he did not quite have it right when thinking about my work as a forensic psychologist. I don't often channel the dead but it really would make my job easier if I had to predict the likelihood of future violence for someone who died. A number of students come to me interested in using their psychology or criminal justice major and the knowledge of human behavior they have acquired to "catch the bad guys." I usually explain to these students that rarely are forensic psychologists called upon to apprehend suspects; in fact, a study found that only about 10% of forensic psychologists and psychiatrists have ever engaged in **criminal profiling** and only about 17% even believed it was a scientifically reliable practice (Torres, Boccaccini, & Miller, 2006). Most students who are interested in catching criminals should look into law enforcement rather than forensic psychology. However, if you are still interested in forensic psychology as a possible career, you should know that you do get to spend a considerable amount of time playing detective, but more on that later.

The Origin of Forensic Psychology

Part of the public's misconception regarding forensic psychology stems from a lack of awareness about the very origin of the word *forensic* itself. Although some people think about forensic science and law enforcement when they think of forensic psychology, others might think about high school speech and debate. Focusing on solving arguments or being verbal adversaries in a speech and debate competition actually brings us a little closer to the true meaning of forensic psychology. The word *forensic* originated from the Latin word *forensis*, which means *of the forum* and was used to describe a location in ancient Rome. The Forum was the location where citizens resolved disputes, something akin to our modern-day courtroom, and conducted the business of the day (Blackburn, 1996; Pollock & Webster, 1993). From this context evolved the meaning of forensic psychology. The role of the forensic psychologist is really pretty simple and straightforward: forensic psychologists assist the legal system.

Box 1.1. A Focus on Research: Criminal Profiling in Forensic Practice

Torres, Boccaccini, and Miller (2006) conducted a study examining the attitudes of forensic psychologists and psychiatrists in part to assess the general acceptance of criminal profiling as a way to address issues of its admissibility in court. We will discuss the importance of the idea of general acceptance in terms of the admissibility of expert testimony in courts in Chapter 3. Nonetheless, psychologists routinely survey mental health professionals to obtain an understanding of the frequency of different techniques used in the profession as a way to identify strengths and weaknesses in our practice of forensic psychology and assess whether a given approach should be admitted into court based on the respect it has in the profession. As a result, Torres and colleagues surveyed 1,637 psychologists and psychiatrists over the internet by soliciting members of different professional groups and received responses back from 161, only a 9.9% response rate. On the survey they asked five primary questions, but alternated whether they asked the questions first about *criminal profiling* or used the term *criminal investigative analysis*, a word that has been used more frequently in lieu of criminal profiling because criminal profiling frequently has a negative connotation among mental health professionals. Generally speaking, the results did not find that participants answered the questions differently based on the terminology. Overall, only 31.5% of respondents said they were knowledgeable about criminal profiling, 16.3% had training in it, 10.9% had generated a criminal profile, 9.8% had ever testified in court about criminal profiling, and 10.9% had ever been asked their opinion about criminal profiling in court before. Most interestingly, respondents who were generally more knowledgeable about the admissibility criteria for experts in court believed that criminal profiling had less scientific merit. Psychologists were generally more knowledgeable about admissibility than psychiatrists as well.

The study can be critiqued in ways that are typical of survey approaches. First, the response rate was generally poor. In such studies, response rates approaching 30% or 40% are more common. The reason that the response rate matters is that you are hoping as a researcher that the people who respond to your survey are similar to the people who did not respond. The greater your overall response rate, the more confident you are of this outcome. A low response rate means that these results may not be true of the wider audience of forensic mental health professionals.

Our Definition of Forensic Psychology

Not only is there confusion in the general public about forensic psychology, but there is even debate among psychologists about the nature of forensic psychology (Brigham, 1999; Hess, K. D., 2006). This debate has occurred not only in the United States, where reforms in mental health law and increasing pressure from the courts for clinical testimony have led to growth in the field, but also in Canada, Europe, and other parts of the world (Blackburn, 1996; Ogloff, 2004). Broadly speaking, forensic psychology refers to any application of psychology to the legal system. However, many refer to this broader field as *psychology and the law* or *psycholegal studies* while specifying that forensic psychology focuses on the application of **clinical psychology** to the legal system

(e.g., Huss & Gonsalves, 2009). This narrower definition of forensic psychology excludes topics such as eyewitness identification (cognitive psychology), polygraphs (physiological psychology), jury behavior (social psychology), and the testimony of children in court (developmental psychology). These other nonclinical aspects have a powerful impact on the legal system and are extremely important in the psychological study of the law, but they are beyond the scope of the current text. Students should check other sources if they have interest in these aspects of psychology and the law (e.g., Brewer & Williams, 2005; Costanzo & Krauss, 2012; Greene & Heilbrun, 2010; Weiner & Hess, 2006).

We will focus on the aforementioned narrow definition of forensic psychology in this book, concentrating solely on the practice of clinical psychology and its intersection with the law. The clinical practice of psychology generally focuses on the assessment and treatment of individuals within a legal context and includes concepts such as psychopathy, insanity, risk assessment, personal injury, and civil commitment (Huss, 2001a, 2001b). Furthermore, we will generally avoid topics that are more characteristic of police psychology (criminal profiling, fitness for duty evaluations, hostage negotiation) or correctional psychology that focuses on issues pertinent to correctional facilities (prisons and jails) but that do not lead to assisting the courts directly.

In using this definition of forensic psychology, we must also differentiate the practice of forensic psychology from forensic psychiatry. Clinical and counseling psychologists are often confused with psychiatrists. Although both psychologists and psychiatrists are trained to assist individuals with mental illness and emotional difficulties in general, there are significant differences (Grisso, 1993). Psychiatrists are medical doctors and obtain MDs or DOs. Psychologists typically obtain PhDs or PsyDs. As a result, psychiatrists are licensed to prescribe medication and emphasize this aspect of patient care. Traditionally, psychologists have not focused on the administration of medication, specifically psychotropic medication, and instead have focused on the psychological assessment and treatment of the mentally ill (see Chapter 2). Psychologists also usually have more extensive training in conducting research (Grisso, 1993) and are therefore better suited to examine many of the ideas we will discuss in this book. There will be issues we focus on that are relevant both to forensic psychology and forensic psychiatry; nonetheless, we will discuss them from the perspective of the forensic psychologist.

History of Forensic Psychology

Forensic psychology has a deep and extensive history that developed long before popular culture began to focus on it. See Table 1.1 for a brief list of important events in the development of forensic psychology. Hugo Munsterberg is often identified as one of the first psychologists to apply psychological principles to the law in his book *On the Witness Stand* (1908). The German psychologist, William Stern, also focused on the application of psychological principles to the legal system by studying eyewitness identification in the early 1900s. However, the clinical practice of psychology, as it relates to the legal system, began separately but at about the same time. The clinical practice of forensic psychology is often attributed to Lightner Witmer and William Healy. Witmer began teaching courses on the psychology of crime in the early 1900s and Healy

Table 1.1. Important Events in the Development of Forensic Psychology

1908	Publication of *On the Witness Stand* by Hugo Munsterberg
1908	Lightner Witmer teaching courses on the psychology of crime
1909	Establishment of the Chicago Juvenile Psychopathic Institute
1921	Psychologist allowed to testify as an expert witness in *State v. Driver*
1962	Psychologists could testify in cases of insanity in *Jenkins v. United States*
1969	Creation of the American Psychology-Law Society
1970s	Founding of scholarly journals that publish articles exclusive to forensic psychology

established the Chicago Juvenile Psychopathic Institute in 1909 to treat and assess juvenile delinquents (Blackburn, 1996; Brigham, 1999), thereby serving as the first significant examples of forensic clinical psychologists.

As psychology, and specifically the practice of clinical forensic psychology, began to develop in North America during the twentieth century, psychologists were called upon to apply their rudimentary knowledge to the legal system as expert witnesses (see Chapter 3). For example, a psychologist was allowed to testify as an expert witness in the United States in *State v. Driver* (1921) on juvenile delinquency (as cited in Johnstone, Schopp, & Shigaki, 2000). Though the court later rejected the testimony (Johnstone et al., 2000), this event still marked an important step in the development of forensic psychology. Court decisions such as *State v. Driver* tended to legitimize the profession, provided a market for forensic psychologists, and indicated that the legal system sought out psychology as another tool in arriving at fair and just legal outcomes. Nonetheless, clinical psychologists were frequently limited in their testimony and often were not allowed to offer a diagnosis because the courts believed that diagnostic impressions could only be offered by medical professionals, mainly psychiatrists.

An appeals court ruling in the District of Columbia, *Jenkins v. United States* (1962) marked an even more significant turning point for the entire field of forensic psychology. In *Jenkins*, the court ruled that psychological testimony could be admitted to determine criminal responsibility (i.e., insanity). Forensic psychologists now routinely evaluate and testify in insanity cases in the United States. These evaluations are necessary to determine whether defendants exhibit sufficient mental capacity at the time of their crimes to be held responsible for them. Prior to the *Jenkins* ruling, psychological testimony on insanity had largely been excluded in favor of testimony by physicians and psychiatrists (Van Dorsten, 2002). *Jenkins* is one of the first examples in which the law and the legal system influenced both research and the practice of forensic psychology. Specifically, it can be argued that the decision in *Jenkins* led to a boom in forensic psychology in the United States during the 1960s and 1970s because of the courts willingness to admit a variety of nonmedical testimony (Loh, 1981). Although the Canadian legal system has arguably been less willing to allow psychologists to testify in court, there have been changes to increase their involvement (Schuller & Ogloff, 2001). Now that psychologists are increasingly being utilized by the legal system, a variety of additional signs point to growth in the field. The largest and possibly most prominent professional organization in forensic psychology, the American Psychology-Law Society,

was first established in 1969 and has grown to over 3,000 members (Grisso, 1991; Otto & Heilbrun, 2002). Furthermore, several forensic-related journals in psychology such as *Law and Human Behavior* and *Behavioral Sciences and the Law* began publication in the 1970s (Melton, Huss, & Tomkins, 1999). All of these advances suggest a vibrant and growing profession. Today the number of journals devoted to forensic psychology topics and the number of graduate programs available has increased even further (see Adherhold, Boulas, & Huss, 2011, for a list of graduate programs).

Major Areas of Forensic Psychology

The nature of forensic psychology is probably still not totally clear to you. One way to get a better idea about forensic psychology is to examine the major areas of forensic psychology and the law itself. Typically, forensic psychology can be divided into criminal aspects and civil aspects (see Table 1.2 for examples of forensic psychology in both). This division of the roles and tasks of forensic psychology is based on the legal separation between civil and criminal law. **Criminal law** focuses on acts against society; it is the government that takes the responsibility for pursuing criminal matters through law enforcement officers and prosecutors. The focus of criminal law is to punish offenders in order to maintain a societal sense of justice and deter crime. The murder that may have occurred last night or the mugging down the street are considered violations of criminal law because we, as a society, do not consider these behaviors appropriate and consider violations of criminal law an offense against any one of us. The state, or the government, acts on behalf of society as the prosecution and files criminal charges against a defendant when it believes an individual has violated criminal law.

There are a number of legal issues specific to criminal law that often play a role in the practice of forensic psychology. For example, **mens rea** is a principle of criminal responsibility that relates to an individual's mental state. Mens rea, or guilty mind, means that an individual has committed an unlawful act willfully or purposefully. It goes to suggest the culpability or blameworthiness of a defendant. Although psychologists are not called upon to render an opinion in every criminal case as to whether a defendant suffered from a guilty mind, they are called upon in select instances. These instances usually focus on the issue of insanity. In insanity cases, it is the responsibility of the forensic psychologist to assist the court in identifying whether a defendant suffered

Table 1.2. Example Areas of Forensic Practice in Criminal and Civil Law

Criminal law	Civil law
Risk assessment at the time of sentencing	Child custody
Insanity and criminal responsibility	Civil commitment
Competency to stand trial	Personal injury
Treatment of sexual offenders	Worker's compensation
Juvenile transfer to adult court	Competency to make medical decisions

from a mental illness and if it prohibited him from forming mens rea and therefore committing the crime intentionally. Other relevant instances in criminal law may include when a juvenile or mentally retarded person is facing the death penalty. Supreme Court cases have ruled that offenders under the age of 18 (*Roper v. Simmons*, 2005; Box 1.2) and defendants suffering from mental retardation (*Atkins v. Virginia*, 2002) do not have sufficient mental capabilities to form mens rea and are not legally responsible for a capital offense. Therefore, they cannot be executed.

In contrast, any violation of civil law is considered a wrong against an individual. **Civil law** is concerned with private rights and remedies, not necessarily the public good. If I get into a car accident because I am driving too fast and hit another person, I can be held civilly responsible because I have damaged that person in some way. **Torts** fall within civil law and consist of a wrongful act that causes harm to an individual. Furthermore, it is up to that harmed individual, not society, to take action. Torts consist of four different legal elements or legal requirements for a violation of civil law to have occurred. In order for a tort to have taken place: (1) an individual must owe a duty; (2) that duty must have been violated; (3) the violation of that duty must be the proximate cause of a suffered harm; and (4) the harm that occurred must involve a legally protected right (see Douglas, Huss, Murdoch, Washington, & Koch, 1999).

Box 1.2. A Supreme Court Decision in *Roper v. Simmons* (2005)

The issue of mens rea was part of the landmark decision in *Roper v. Simmons* (2005). In 1993, Christopher Simmons planned and carried out the murder of Shirley Crook only seven months before his 18th birthday. The crime was not sudden and impulsive. Simmons explained his plan in great detail to two of his friends who he attempted to involve in the murder. He told them that they would break into a house, rob it, tie up a victim, and toss the victim off a bridge. He even bragged to them that they would get away with it because they were minors. On September 9, 1993, Simmons and his friends met up to carry out the plan. However, one of his friends decided not to participate. As a result Simmons and his only accomplice, Charles Benjamin, went to the home of Shirley Crook. They broke into the house, bound Mrs. Crook with duct tape, loaded her inside her own mini-van, and drove to a nearby state park where they threw her off a bridge. Christopher Simmons was apprehended, convicted of murder, and sentenced to death after he bragged to peers about killing Mrs. Crook.

On appeal, Simmon's attorneys argued that imposition of the death penalty on a juvenile was cruel and unusual punishment because he lacked the mental capacity or mens rea to understand the crime and the sentence. The American Psychological Association filed an **amicus curiae** brief with the court asserting that the body of scientific evidence clearly indicated that juveniles (individuals under 18) did not have the ability to take full moral responsibility for their choices. The United States Supreme Court agreed and ruled that the death penalty represented cruel and unusual punishment for juveniles because of their insufficient mental capacity to truly understand their actions.

For a tort to have occurred in the car accident I caused above, I must have owed a duty. Generally, it is legally recognized that operators of motor vehicles have a duty or a responsibility not to collide with other drivers or, more generally, to obey traffic regulations. For example, I have a responsibility or a duty to turn left only when there is a green light and no oncoming traffic. If I collided with another driver because I turned left while a traffic light was red, I have violated or breached that duty. A breach of duty can be intentional or a result of negligence. **Negligence** occurs when an individual falls below an ordinary or reasonable level of care. So even if I did not intend to turn when the light was red, it may have been negligent of me to do so because a reasonable person would not have turned at that time. The third element of a tort involves proximate cause. For the third element to be met, my violation of the duty must be the proximate cause to any harm that defendant suffers. Proximate cause is normally considered to be something that naturally follows or occurs in an unbroken continuous sequence of events. If a giant meteor falls from the sky at the exact moment I am turning left on the red light, smashes into the plaintiff's car, and then I collide with the damaged portion of the car, my violation of the traffic regulations is not the proximate cause of his damaged car. The giant meteor falling out of the sky is the proximate cause of his damage, even though I may have met the first two elements of the tort. In order for a harm to occur, the opposing driver must suffer damage to his car, be physically or psychologically injured, or suffer some other kind of harm. In this example, if I've fulfilled the first three elements of a tort but instead only bumped the opposing driver on his bumper so that he did not suffer any damage to his car or his person, a tort would not have occurred because he did not suffer any harm. Civil law generally recognizes that there must be damage because one of the purposes of civil law is to compensate the victim for damage suffered and even to restore him to his prior state, whether that is physically, psychologically, or financially (Douglas et al., 1999).

In civil law, one party, the plaintiff, must bring action against someone who has violated his rights, the defendant. In the above example, assume that my insurance company and I refuse to compensate the person for any damage he suffered. The plaintiff, the person I hit with my car, must file a lawsuit against me and argue that I caused the car accident that resulted in his injuries. In this instance, a forensic psychologist might evaluate the plaintiff to see if he has suffered any psychological damage as a result of the accident. For example, the plaintiff may suffer from **posttraumatic stress disorder** (PTSD) and be afraid to drive or experience significant anxiety when he drives. The plaintiff could ask to be compensated for his emotional trauma and for the cost of any psychological assistance he sought out.

Much of this book will focus on criminal aspects of psychology, topics in which students tend to express a greater amount of interest. However, the civil aspects of forensic psychology are largely understudied, especially given that the civil law may constitute a greater portion of forensic practice as a whole. As a result, some chapters of this text will focus almost exclusively on civil issues (Chapters 12 and 13) as well as discussion of civil aspects such as competency (Chapter 8).

Structure of the Legal System

In the United States, there are two types of trial systems: state courts and the federal courts (see Figure 1.2). In some ways, these two different systems are set up in a parallel fashion. The state courts typically have some sort of entry-level or trial court, **circuit courts**, allow for an appeals process, and a court that functions as the highest court in that state, normally the Supreme Court. The United States federal system is set up in a similar manner. There are entry level trial courts called **district courts**, circuit courts similar to those in the state court system, various types of **appeals courts**, and the United States Supreme Court, which functions as the highest court of appeals in the nation.

Often there is some confusion about these two different legal systems and their ultimate **jurisdictions**. Generally, any violation of state or local criminal and civil codes will be brought to a state court. Any violation of federal law will be brought to a federal court. It is not always apparent which jurisdiction should hear a particular case, though. The legal battle between the former *Playboy* centerfold and actress Anna Nicole Smith and her late husband's children over her husband's will is an example where one of the issues in a given legal case may concern the proper court to hear the case (see Box 1.3). In this case, one of the issues was whether the case should be tried in California or Texas. This question is important because each state has different laws governing wills that may be more or less favorable to one party involved in the lawsuit. There are also a number of specific instances in which the federal courts have jurisdiction, such as when a constitutional issue is central to a case or there is a dispute between two states. Nonetheless, decisions of the United States Supreme Court are not always binding on all state courts. For example, in a case we will discuss in Chapter 3 that focused on the admissibility of expert testimony, *Daubert v. Merrell Dow Pharmaceuticals, Inc.* (1993), the states did not have to follow the ruling of the Supreme Court because it involved

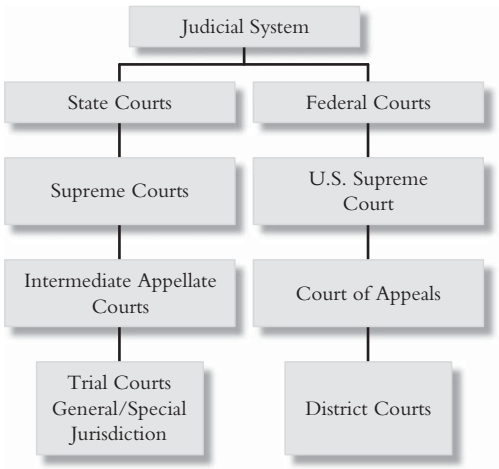

Figure 1.2. The United States Judicial System

an interpretation of federal law, not a constitutional issue. Nonetheless, state courts often listen to the United States Supreme Court when rendering a decision, even if the Court's ruling is not **binding** on them. The court system that may hear a given case can even be dictated by the law enforcement officers or prosecutors. In some instances, law enforcement officers and prosecutors have discretion whether a particular defendant will be charged with a state or a federal crime, though they have committed only a single act. The prosecutor's eventual choice dictates the court system that hears the case.

One final point also should be noted. Most people believe that U.S. legislatures make laws by proposing bills and then passing them with some sort of majority vote. However, laws can originate both from the legislature and the courts. When a state or the federal government enacts a law legislatively, it is referred to as **statutory law**. **Case law** is law derived by a court's interpretation of existing statutory law or instances in which no statute exists. Both statutory law and case law carry equal weight. Sometimes case law is referred to as **common law**, although this term is usually reserved for law

Box 1.3. The Anna Nicole Smith Case

Anna Nicole Smith is relevant to our discussion of forensic psychology because her court case involved two different state courts and the federal court system. Prior to her death in 2007, Anna Nicole Smith was a model, actress, and pop celebrity who rose to fame first as a Playboy Playmate but later appeared in national commercials, her own television show and various movies. Billionaire J. Howard Marshall reportedly promised to marry Ms. Smith on multiple occasions after he met her at a strip club prior to her rise to fame. After her own divorce, she married Mr. Marshall, age 89, when she was 26 years old. Many suspected that it was a marriage of convenience because of the age disparity and Mr. Marshall's wealth.

The legal issues started 13 months after the marriage when Mr. Marshall died. Ms. Smith claimed half of her late husband's estate because of his promise, even though she had been left out of his will. This action led to a dispute with one of her husband's sons, E. Pierce Marshall, that continued for over a decade across several state and federal courts. In 2000, she was awarded almost half a billion dollars by a California court but was denied all proceeds from J. Howard Marshall's estate by a Texas court and ordered to pay $1 million in legal fees to E. Pierce Marshall.

Because there was now a conflict between two different state courts, the battle was moved to the federal court system. In 2002, a federal court reduced her award to $88 million, only for this decision to be completely reversed by the 9th Circuit Court of Appeals when it ruled that Ms. Smith was not a rightful heir and should not receive any of the estate. However, in disputes between states, the United States Supreme Court is the final word. In 2006, the Supreme Court unanimously ruled in favor of Ms. Smith by concluding that she had the right to pursue a share of her husband's estate, but the decision did not award her a portion of the estate. Even though both parties to the case have now died, E. Pierce Marshall in 2006 and Anna Nicole Smith in 2007, their heirs continued the legal battle until the case was ultimately resolved by the United States Supreme Court, which decided that Smith was not entitled to a portion of the estate.

that is not only based on prior judicial rulings but also on custom and tradition. The common law tradition of judge-made law differs from the process in many other countries. The term *common law* suggests an origin in England and countries that previously were colonies in the British Empire. Ireland, Australia, Canada (except Quebec), and the United States are referred to as common law countries because much of their legal systems reflect the notion that judges have the authority to make law.

The Relationship of the Law and Psychology

Remember, I said that forensic psychology was the intersection of clinical psychology and the law. There have been several attempts at trying to explain the relationship between psychology and law. These attempts have ranged from Haney's (1980) tripartite description of psychology in the law, psychology and law, and psychology of law to Monahan and Walker's (2005) theory of social science as falling into social authority, social fact, and social framework. I will not take the time to go into these theories more, but it is important to know that in both instances, these scholars argued for the application of social science research to assist the legal system. A more recent theoretical conceptualization of the relationship between psychology and law is something called **therapeutic jurisprudence**. Therapeutic jurisprudence (TJ) has been defined as "the use of social science to study the extent to which a legal rule or practice promotes the psychological and physical well-being of the people it affects" (Slobogin, 1996, p. 767). Therapeutic jurisprudence includes not only the impact of statutory or case law but also the less formal legal process that may focus on the actions of judges and attorneys. As TJ has spread, it also has been applied more generally to suggest any manner in which the law can be therapeutic (helpful in some way) or antitherapeutic (detrimental in some way). Moreover, the application of TJ does not imply that a particular action must have something to do with psychotherapy or even clinical psychology in general. It means that the law can have an impact outside the routine guilt or innocence of a defendant or the negligence of a defendant in a civil suit. TJ suggests that the impact of law extends beyond the courtroom and can have a profound impact on the practice of forensic psychology and even everyday life beyond that which we routinely assume.

There are a variety of ways in which the legal system can have a beneficial or detrimental impact on the people it affects. For example, if a judge never mandates treatment for domestic violence perpetrators that come before her, that may have a negative impact on the likelihood of that offender perpetrating a similar crime in the future. If an appeals court rules that there is a clear patient–client privilege for psychologists, clients may be more willing to share information with their therapist. The civil commitment laws in a particular state may be written so the homeless are more likely to be civilly committed because they are a danger to themselves under a gravely disability provision. All of these are examples in which we can examine the law from a TJ perspective and hopefully improve the administration and application of the law. In this book TJ will be important because it will highlight how the law can have real consequences on some aspect of forensic psychology, intentionally or unintentionally.

The law can be a living and breathing entity, and this realization is important for our study of forensic psychology. Forensic psychologists must be aware of the consequences of the law and the legal system as they assist the courts. TJ is certainly not the only way to make this clear, and to be honest there is nothing all that profound about TJ. The idea of therapeutic jurisprudence simply highlights some important ways in which the law can have positive and negative ramifications in the practice of forensic psychology and ways in which forensic psychology can assist the legal system.

The Conflict between Psychology and Law

Some would argue that the intersection between psychology and the law is more of a collision. Psychology and the law are two very different disciplines that approach solving problems in very different ways. Haney (1980) and Ogloff and Finkelman (1999) identified several conflicts between psychology and the law. In general, the law tends to be authoritative and psychology tends to be empirically based. This dichotomy suggests that the law is based in precedent. The principle of **stare decisis**, to let a previous decision stand, is at the heart of the law. The courts put great stock in prior legal rulings and are resistant to changing those prior rulings. The legal system is organized in a very hierarchical fashion with specific rules and procedures. Psychology on the other hand focuses on the aggregation of a number of pieces of information with conclusions that may shift across time as the research examines a given question from different perspectives. Psychology accepts that change is likely in our pursuit of the truth.

These two systems also differ in the manner in which they arrive at their respective definitions of the truth. The law uses the adversarial system, at least in Commonwealth countries in which two opposing sides are assumed to use maximum effort to achieve victory. It is assumed that the truth will be revealed as a result of these two sides doing their best. This approach is often in conflict with psychology that instead uses experimentation through objective research. Though there are times that bias is introduced into the empirical process, the intent is to reveal an objective truth. The law and psychology are also different in that psychology is descriptive and the law is prescriptive. Psychology describes human behavior and the law dictates or prescribes how humans should behave. Another fundamental difference between the two is that psychology is **nomothetic** and the law is **idiographic**. Psychology focuses on the aggregate or on broad theories that can be generalized to a number of instances. The law focuses on an individual case or a specific pattern of facts. Finally, psychology is probabilistic and the law is definitive. Psychology talks about the likelihood of a given event occurring. In contrast, the law attempts to be certain. A defendant is either guilty or not guilty. Either evidence is admissible or it is not admissible.

Of course, all of these differences are artificial in some way because they are conceptualized along a dichotomy and not a dimension. None of these differences are true for either discipline in every single instance, but they are generally truer of one discipline than the other. More importantly, these differences go to the core of the conflict between these two disciplines and often cause difficulty for psychologists choosing to work within the legal system. For example, a local defense attorney once asked me to

testify in a case in which a woman assaulted her husband. In doing so she wanted me to testify about the relevance of battered woman's syndrome (see Chapter 3) and its applicability to her client. However, there is little valid, scientific research to support the unique constellation of traits that has been described as battered woman syndrome (BWS) and the characteristics that separate it from PTSD. However, she was convinced that BWS was the best trial strategy in this case and did not care if there was little scientific support for it. Her job was to defend her client. My job was to present the scientific research objectively. Ultimately, I did not testify in the case, largely because the attorney believed my interpretation of the scientific literature would not assist her client. Forensic psychology is littered with these types of conflicts and we will examine them throughout the entire book.

Education and Training in Forensic Psychology

How Do I Become a Forensic Psychologist?

The question of how to become a forensic psychologist is a complex one. Asking this question might be putting the proverbial cart before the horse. For example, how many people grow up hearing the question, "What do you want to be when you grow up?" All of us have heard it at one time or another. How many of us reply to it by stating, "I want to be a graduate student!" It is unlikely that any of us offered that reply even if we knew what graduate school was as a child. However, someone interested in being a forensic psychologist must realize that there is a means (graduate school) to reach the goal (becoming a forensic psychologist) and that graduate school may not be for everyone. In addition, there is not one single way to become a forensic psychologist, but a variety of paths that take you toward your eventual goal (Huss & Gonsalves, 2009).

If you are interested in becoming a forensic psychologist, you will need to seek admission into a graduate program in psychology. However, the nature of that program will be as varied as the different roles and responsibilities of forensic psychologists. The first question you should ask yourself is this: is a doctorate or a master's degree the best option for me? There are several different publications that speak to the advantages and disadvantages of doctorate and master's programs in general (e.g., Actkinson, 2000). In addition to these general considerations, there are also some issues specific to forensic psychology that should be considered. Most students interested in forensic psychology focus on obtaining a doctorate degree (PhD or PsyD). Although doctorate programs provide the most professional flexibility and have advantages over a master's program, you can also hash out a viable career in forensic psychology after obtaining a master's degree. Please know that the title "psychologist" is reserved in most jurisdictions for those having a doctorate and not a master's degree. Nonetheless, pursuing a master's degree can provide you with similar professional experiences and entails many advantages over a doctorate. Master's programs have less competitive admission standards, take less time to complete, allow you to earn a professional salary earlier, may be more plentiful in a given geographic location, and are more likely to allow for part-time

study. In addition, research has suggested that there are no obvious differences in the quality of service provided by master's-level and doctoral-level clinicians in general (Clavelle & Turner, 1980), though it is unclear whether this finding also applies to forensic work. Those who earn doctorate degrees generally have several distinct advantages over the master's-level clinician. These advantages include a greater breadth and depth of practice, greater annual salary and the ability to practice more independently, depending on where you live and the licensure laws governing the practice of psychology. These advantages may be accentuated in forensic psychology, specifically because of the necessity of assessment and evaluation skills in forensic practice.

Models of training in forensic psychology

Joint-degree programs The next point to consider is the model or type of training you would like to pursue. Many students think that in order to become a forensic psychologist you need to obtain degrees in both psychology and the law (Melton et al., 1999). They then become dejected when they are unable to gain admission to one of the few joint-degree programs. However, the joint-degree is only one way to become a forensic psychologist and may not be the best route. Furthermore, admission into a joint-degree program is very competitive because of their scarcity and the high admission requirements for most programs. A **joint-degree program** is a program in which you obtain both a law degree (typically a JD or Juris Doctorate) and a psychology degree (PhD or PsyD). Some schools, such as the University of Nebraska, offer a variety of different degree combinations (PhD/MLS and MA/JD). There are not currently any formal joint-degree programs in Canada, but students in Canadian forensic psychology programs have obtained LLBs (Bachelor of Laws), the equivalent to JDs outside of the United States, informally during their training. A joint-degree program may be advantageous because it allows training in the two disciplines simultaneously, which increases the chances of a true understanding of the integration of psychology and the law. Obtaining degrees in two disciplines also may increase career options. Although it might seem appealing to get both a law degree and psychology degree, there are drawbacks (see Melton et al., 1999).

The disadvantages of pursuing the joint-degree route concerns the time, expense, and effort involved in obtaining two advanced degrees. There is a reason that joint-degree programs are rare and have competitive admission standards. They simply are not for everyone. It is difficult to transition between two different disciplines, much less two different faculties, ways of thinking, or even campus locations. You also are in school longer; as I suggested before, children do not grow up yearning for the glory of a life as a graduate student. While you are in school, you are not earning a professional income, you are living at or below poverty, and you may be incurring additional expenses such as paying tuition or school loans. Students tend to underestimate the limitations that student loans will have on future professional and personal choices. Most PhD programs do offer financial assistance in the form of tuition remission or paid assistantships, but these tend to be rarer for students in dual-degree programs during the legal portion of their training. Furthermore, obtaining a joint-degree does not necessarily mean you will have more career options. As Melton et al. (1999)

mention, if you have a psychology-related job, others may wonder if you are going to be an attorney some day, whereas if you have a legally related job, others may wonder why you have this PhD and how it is going to be useful in practicing the law. Although knowledge of the law is necessary, one certainly does not need to obtain a law degree to acquire this knowledge and function as a forensic psychologist. As a result, students should consider seriously whether the joint-degree is the best option for them to become a forensic psychologist.

Specialty programs Another model of training for forensic psychology is to attend a graduate program that specializes in forensic training. In these specialty programs, students will focus on obtaining a degree in clinical or counseling psychology but also receive some specialized training in forensic psychology. The specialized training may consist of seminars in forensic related issues, practicum or clinical placements in forensic facilities, or even taking a few law school courses. Students who attend these specialty programs often engage in many of the same activities as the joint-degree students. However, they will not fulfill the requirements to obtain a law degree and may have greater difficulty with the integration of psychology and the law. A program such as the one offered by Simon Fraser University in British Columbia, Canada, is an example of a program with a special emphasis in forensic psychology. The programs that offer an emphasis in forensic psychology are also more plentiful than joint-degree programs and may offer a broader training in clinical or counseling psychology in general (see Table 1.3 or http://www.ap-ls.org/education/GraduatePrograms.php for comprehensive lists of both types of forensic psychology programs). At least one program, the

Table 1.3. List of Forensic (Clinical/Counseling) Psychology Doctoral Programs per Model of Training

Joint-degree programs	Specialized programs
Drexel University/Villanova Law School University (JD/PhD)	Drexel University (PhD)
Palo Alto University (JD/PhD)	Fairleigh Dickinson University (PhD)
University of Leichester (MLS/PhD)	Fordham University (PhD)
University of Nebraska (JD/PhD, MLS/PhD, JD/MA)	John Jay College of Criminal Justice (PhD)
Simon Fraser/University of British Columbia (JD/PhD)	Nova Southeastern University (PhD/PsyD)
Widener University (JD/PsyD)	Palo Alto University (JD/PhD)
	Sam Houston State University (PhD)
	Simon Fraser University (PhD)
	Texas A & M University (PhD)
	Texas Tech University (PhD)
	West Virginia University (PhD)
	University of Alabama (PhD)
	University of Leicester (PhD)
	University of Nebraska (PhD)

University of Nebraska, even offers both a dual-degree and specialty option. There are also programs that offer a master's degree in forensic psychology, not one in clinical or counseling psychology. As always, a student should make sure that these programs afford the opportunity for licensure immediately upon graduation if the student wants to practice forensic psychology. I have heard of anecdotal instances when students were unaware of these limitations until they were in the program or had even completed it. Forensic doctorate programs, again opposed to forensic psychology programs within clinical or counseling psychology programs, are generally not available. They may also be unadvisable; the American Psychological Association has shown some resistance to accredit programs with a narrow focus only in forensic psychology.

General programs Most forensic psychologists have not obtained their degrees from a joint-degree or specialty program. Instead, they have attended a general program in clinical or counseling psychology. They may have participated in a practicum at a local prison, obtained a predoctoral internship at an institutions that focused on forensics after they completed their coursework, or pursued a postdoctoral training opportunity after they graduated with their PhD. Although none of these options affords the same depth of forensic training you receive in the joint-degree and specialty programs, they are more plentiful and allow for a greater breadth of training. For example, you may enter graduate school thinking you want to be a forensic psychologist and then realize after obtaining some experience that it is not the best option for you. These general programs are more likely to allow you to obtain experience in a number of areas of clinical psychology and not force you to focus on forensic psychology so early in your professional development. It is not clear that any of these options are superior to the others in all aspects. It really depends on the individual student and his or her personal and professional objectives.

Levels of forensic training

No matter the general model that a program falls within, Bersoff et al. (1997) proposed three different levels of proficiency that any clinical program could offer in training forensic psychologists. The lowest level is called the *legally informed clinician* and is based on the idea that every psychologist must be prepared to be a potential expert witness and that forensic issues are part of any general clinical practice. A legally informed clinician is one who does not call him or herself a forensic psychologist but who is educated in some fundamentally forensic ideas, as the law applies to even basic practice in clinical psychology. A legally informed clinician is educated in issues such as confidentiality, privilege, and responding to legal subpoenas for their clinical records (Packer & Borum, 2003). These topics would be included in routine courses offered in clinical programs such as required ethics, clinical assessment, and psychotherapy (Bersoff et al., 1997). The *proficient clinician* receives specialized training in forensic psychology, such as course work and clinical training in forensic hospitals, prisons, and juvenile detention facilities; preparing forensic assessments; and testifying as an expert witness (Bersoff et al., 1997). This level of expertise allows clinical psychologists who have not specialized in forensic psychology to engage in some limited forensic work. For example, someone who is a child psychologist may

want to conduct a limited number of custody evaluations. *Specialist clinicians* have reached the highest level of this theoretical training, which consists of an integrated educational experience designed specifically to train forensic psychologists. Specialist clinicians would receive extensive training in case law and forensic practice skills across a variety of different patient populations. There appears to be an increasing emphasis on specialization in forensic psychology (Packer & Borum, 2003). This emphasis may not only encourage graduate programs to provide forensic training but also to require forensic postdoctoral training and certification at an advanced level of ability by organizations such as the American Board of Professional Psychology (ABPP). Finally, it should be made clear that any amount of training does not allow someone to practice as a forensic psychologist. In order to practice forensic psychology, you must be licensed as a clinical or practicing psychologist in a given state. Students should make sure that their program, no matter the model or the level of training they subscribe to, produces graduates who meet general licensing requirements and can actually practice psychology.

DeMatteo et al. (2009) further proposed that forensic psychologists should obtain training in several specific areas at a minimum. They suggested that forensic psychologists should receive training in substantive psychology, research design–methodology and statistics, conducting research, legal knowledge, integrative law–psychology knowledge, ethics and professional issues, and clinical forensic training. *Substantive psychology* includes the major content areas of psychology such as clinical, developmental, learning, cognitive, and physiological. They recommended sufficient *research design–methodology and statistical* training to conduct independent research and/or be an effective consumer of research. For the *conducting research* component they suggested that an empirical dissertation was sufficient for meeting this area but that students enrolled in PsyD programs that might not require empirically based dissertations would be exempted from this requirement because many PsyD programs may not require an empirical dissertation. *Legal knowledge* included foundational courses in legal systems and sources of law as well as classes across criminal and civil law as well as substantive areas of the law that were relevant for individual training (e.g., competence to stand trial). *Integrative law–psychology* courses include foundational courses in forensic psychology such as forensic treatment and assessment. *Ethical and professional issues* include basic informational focus on forensic research and practice issues. Finally, *clinical forensic training* should include clinical training in forensic assessment, treatment, and consultation. Interestingly, DeMatteo and colleagues reviewed some of the available information from forensic programs and identified that only 40% of the programs offered courses that would fall under legal knowledge, all offered courses that would fall under the integrative law–psychology area, only three offered a forensic-focused course in ethics and professional issues (though all offered a general ethics course), and nearly all offered clinical forensic training.

Careers in Forensic Psychology

As the legal system began to recognize the benefit of psychology, career opportunities also expanded (Roberson, 2005). As we will discuss in Chapter 2, forensic psychologists typically engage in three primary activities: assessment, treatment, and consultation. For

example, a forensic psychologist may evaluate a defendant for insanity (Chapter 9) or attempt to determine the best interests of a child in a custody situation (Chapter 12). A forensic psychologist may attempt to restore the competency of a defendant so he can stand trial (Chapter 8). A forensic psychologist may assess psychopathy in an individual (Chapter 4) who could be released from prison as part of a risk assessment to determine his potential for future violence (Chapter 5). The forensic psychologist may then testify at a hearing or a trial about his or her findings. However, most legal issues are resolved without the forensic psychologist testifying as an expert (Chapter 3). With the emergence of forensic psychology has come an ever-widening array of career options. Forensic psychologists work in a variety of settings such as jails and prisons, state hospitals, law enforcement agencies, state and federal government agencies, community clinics, juvenile detention facilities, private practices, and even colleges and universities. In any of these settings, a forensic psychologist may work as an administrator, therapist, researcher, or **policy evaluator**. A good source of information on careers in forensic psychology, and the broader field of psychology and law, is available from AP-LS (Bottoms et al., 2004).

Reflection and Review

1. In what types of jobs and tasks do forensic psychologists typically engage?
2. What are the different ways you can define forensic psychology?
3. What are some of the more important historical events in the development of forensic psychology? Why is *Jenkins* so important?
4. How do criminal law and civil law differ?
5. What are some of the differences between psychology and the law that make the intersection challenging?
6. What are the advantages and disadvantages of joint-degree programs, specialty programs, and general programs?
7. What do experts recommend in terms of obtaining the necessary training to become a forensic psychologist?

Key Terms

amicus curiae
appeals court
binding
case law
circuit court
civil law
clinical psychology
common law
criminal law
criminal profiling
district court
forensic psychology
idiographic
joint-degree program
jurisdiction
mens rea
negligence
nomothetic
policy evaluator
posttraumatic stress disorder
stare decisis
statutory law
therapeutic jurisprudence
torts

Further Readings

American Psychology-Law Society: http://www.ap-ls.org/

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2 Assessment, Treatment, and Consultation in Forensic Psychology

Chapter Objectives

1. Identify the differences between therapeutic and forensic assessments
2. Describe the major methods of assessment
3. Know the difference between forensic and correctional psychology
4. Understand the diversity in offender populations in the context of treatment
5. Identify successful components of treatment
6. Distinguish between consultation and the other areas of forensic psychology

So far you have received an introduction to forensic psychology, but in this chapter we will take a closer look at the major areas involved in the practice of forensic psychology. Forensic practice can be divided into three specific areas: assessment, treatment, and consultation. The first two areas are not unique to forensic psychology but are central to the practice of clinical psychology. They therefore may be somewhat familiar to you if you have had a course in abnormal psychology or clinical psychology. Forensic assessment normally consists of the evaluation of an individual in an attempt to assist the courts in addressing a legal question. As a result there are a number of ethical considerations that are somewhat unique to a forensic assessment (see Chapter 3 for a complete discussion). Forensic assessment relies on similar methods and tools as a general therapeutic assessment but also uses some forensic-specific methods. In discussing psychological treatment in a forensic context, we will largely focus on criminal offenders, mentally ill or not, and aspects of treatment that are especially relevant. The third area, consultation, is something that is more likely to occur in forensic practice than routine clinical practice and therefore may be unfamiliar to most students. Consultation is an often ignored but extremely important role for forensic psychologists who frequently assist attorneys or the courts themselves in understanding aspects of human behavior

and mental health that do not directly involve the assessment or treatment of individuals. Nevertheless, the consulting forensic psychologist is engaged in a crucial aspect of forensic practice that may be growing in scope and frequency (Andrews, 2005).

Forensic Assessment

When discussing assessment from a clinical psychology perspective (i.e., a therapeutic assessment), the focus is on gathering information about an examinee to make a diagnosis or conclusion about his or her current psychological functioning. When a client walks into a psychologist's office, an emergency room, or a psychiatric hospital, he or she may be subjected to a psychological interview or given psychological tests. Third-party information may also be gathered through interviews of those close to the client or a review of existing records. In forensic assessment, the focus is not only on gathering information that allows the forensic psychologist to make a conclusion about the examinee's mental health, but to do so in order to inform the court (Heilbrun, Grisso, & Goldstein, 2009). As mentioned previously, these methods are grounded in the same methods that clinical psychologists use to assess anyone presenting with a mental health concern and consist of interviewing, psychological testing, and gathering archival and third-party information. The difference is that in a forensic context these methods take on added importance because they have far-ranging implications beyond an accurate diagnosis and may extend to the person's freedom or the well-being of society (see Figure 2.1).

Important Tasks in Forensic Assessment

A **therapeutic assessment** is designed to diagnose an individual so that an intervention can be developed and the person's suffering reduced. However, a forensic assessment is different from a traditional therapeutic assessment because there are two additional tasks involved in a forensic assessment. Forensic assessments must clarify and identify the legal question and assess whether forensic psychology has something to offer in a specific situation. Grisso (2003a) has written extensively on the importance of making forensic assessments legally relevant, and this will be a topic we examine at various times throughout the book.

It is surprising that sometimes the court or legal parties are not completely clear about their need for a psychologist or the precise legal question to be addressed. An attorney once approached me and stated that his client was as "crazy as a jaybird." It would have been difficult for me to evaluate this examinee to see whether he actually met the threshold requirement for "jaybird craziness." However, after talking more with the attorney, it became clear that he was concerned about his client's ability to assist him during his trial. The client may have also suffered from a mental illness that would become an important consideration at sentencing if he were convicted of the crime.

Alan Diaz/© AP/Wide World Photos

Figure 2.1. In the case against Jose Padilla, who was accused of plotting a dirty-bomb attack in the United States, a forensic psychologist assessed Padilla and testified that he suffered from PTSD.

There are also times when the court approaches a psychologist and the forensic psychologist may not have anything to offer the court. For example, there are times when the psychological literature does not support a legal assumption or strategy. An attorney approached me asking for an opinion on some drawings involving a defendant he was prosecuting for a sexual crime. The drawings were unusual and a little disturbing, but there was nothing I could point to in the literature that would suggest they were characteristic of someone likely to perpetrate a sexual crime. I told him that I could not testify as to any relationship between the pictures and a sexual crime, but I could testify that the defendant's behaviors were suggestive of grooming techniques used by child molesters (see Chapter 6). He was more than satisfied with that approach, so I did end up testifying, but not on the original topic he thought would be of interest. The interesting part of this case was that the defense attorney tried to get me to testify regarding the pictures and I told him I was unable to do so. I probably looked more credible in the court's eyes as a result.

Core Concepts in Assessment: Reliability and Validity

Before we discuss specific aspects of therapeutic and forensic assessment, it is important to review two important concepts that are central to assessment, and specifically, psychological testing. Reliability and validity are terms that can describe the measurement or psychometric soundness of a given test or procedure. **Reliability** generally refers to the consistency of measurement. For example, someone who suffers from depression should obtain a similar score across multiple administrations of a psychological test designed to assess depression, like the Beck Depression Inventory-II (BDI-II). If a person is tested from week to week and her symptoms do not change, her scores should be similar each week. If a depressed person's scores vary widely with repeated administrations of the measure while his or her symptoms remain largely unchanged, it would suggest poor reliability for that measure. On the other hand, **validity** is the accuracy of measurement. In order for the BDI-II to be valid, it needs to measure depression and not something else. A measure of depression should not assess something like the amount of physical exercise one experiences or something unrelated such as the frequency of watching a television show like *American Idol*. Higher levels of both reliability and validity suggest that a procedure or test is sound enough to be used. Reliability and validity are generally expressed by a correlation that ranges from −1 to 1, with a higher correlation indicating better reliability and better validity. One aspect of reliability and validity that is often an issue in forensic assessment is that general clinical procedures and tests are frequently adapted for use in a forensic context without their reliability and validity being properly determined via scientific research (Butcher, 2002; Rosenfeld, Edens, & Lowmaster, 2011). As we will discuss in Chapter 3, this is an issue when we encourage forensic psychologists to practice within their area of expertise or **scope of practice**. Although students may grow tired of conversations about mundane things like reliability and validity, they are central to forensic practice and will be discussed both explicitly and implicitly in future chapters.

Distinguishing Therapeutic Assessment from Forensic Assessment

Traditional therapeutic or clinical assessments differ from forensic assessments in a number of important ways (Goldstein, 2003). Some of the ways in which they differ include (1) goals and objectives, (2) relationship of the parties, (3) identity of the client, (4) consequences, and (5) examinee's perspective (see Table 2.1). These differences focus on core overlapping areas between therapeutic and forensic assessments. In addition to these fundamental differences, forensic assessments include two additional requirements: (1) identification of the legal question and (2) an assessment of whether the forensic psychologist can assist the court.

The first way in which therapeutic assessment differs from forensic assessment is in the *goals and objectives* of each approach. The objective of a therapeutic assessment is to help the examinee by diagnosing and then treating the person for the relevant emotional and psychological problems (Heilbrun, 2003). The objective of a forensic assessment, by comparison, is to assist the court. The forensic psychologist may diagnose an

Table 2.1. Differences Between Therapeutic and Forensic Assessment

	Therapeutic assessment	**Forensic assessment**
Goals and objectives	Gather information to reduce psychological suffering	Address a legal question
Relationship of parties	One of care and support	Investigative and truth seeking
Identity of client	Client is the examinee	Individual who seeks out and pays for the services
Consequences	Design an intervention	Financial or loss of liberty
Examinee's perspective	Most important source	Heavily scrutinize examinee

individual with a mental illness, but instead of treating that person, the forensic psychologist may simply inform the court of the manner in which this mental illness impacts the defendant's decision making or ability to function in a legal context. This difference does not mean the forensic psychologist is without compassion or that the examinee should not or will not be helped; rather, it means that the primary objective in the assessment itself is not to provide information to inform treatment, but rather some legal purpose.

The *relationship* between the evaluator and the examinee is different in a forensic assessment. In a therapeutic assessment, the role of the therapeutic psychologist is to exhibit concern and offer support. An important part of the therapeutic assessment is to build rapport in order to help the examinee through his emotional difficulties. In a forensic assessment the psychologist adopts more of an investigative role in which he or she is focused on an objective examination of the information pertinent to this examinee (Craig, 2004). Supporting an individual through the legal process or the relevant psychological difficulties is not typically a consideration in the forensic assessment.

It can even be a challenge to determine the *client* in a forensic assessment, a task that is not normally present in a therapeutic assessment (Ogloff & Finkelman, 1999). In a therapeutic assessment, the client is very clearly the person who has sought your services. It is the person whom you are evaluating, the person you are interviewing, the person responding to the psychological tests. However, the issue can be more complicated in a forensic assessment. The client or clients may not necessarily be the person sitting across from you in the evaluation, because the person who hired you and to whom you owe a duty may be different from the person you are evaluating. In a forensic assessment, the client is more likely to be the court or the attorney who hired you. This difference in the identity of the client is often reflected in the level of confidentiality associated with forensic assessments and the obligation the forensic psychologist has in going further to make the limitations clear, while making sure the examinee is giving his or her informed consent for the assessment.

Therapeutic and forensic assessments also differ in the *consequences* of the evaluation (Craig, 2004). The consequences of a therapeutic assessment usually result in an intervention or treatment approach being designed and implemented for the examinee.

The consequences of a forensic assessment, however, could include a financial reward, a loss of freedom, or even a loss of life. Although the consequences of receiving poor or ineffective treatment should not be minimized, the consequences of a forensic assessment can be more severe.

The accuracy of the information you obtain is generally more questionable in a forensic assessment than in a therapeutic assessment (Melton, Petrila, Poythress, & Slobogin, 2007). During a therapeutic assessment the *examinee's perspective* is heavily relied upon because it is voluntary and there is a shared course of action between the evaluator and the examinee. During a forensic assessment the examinee may not present himself voluntarily, the evaluator questions or waits for verification of his statements, and the examinee has something to gain from the outcome of the assessment beyond a reduction in psychological suffering because of a mental illness. As a result, accuracy of the information is much more likely to be at question in a forensic assessment than a therapeutic assessment, and the importance of the examinee's perspective varies. We will discuss the potential issue of malingering as it relates to forensic assessment later in this chapter.

Methods and Procedures: Interviewing

Despite the procedural differences between therapeutic and forensic assessment, there are also a number of similarities. Among them is the cornerstone of assessment—the clinical interview. Interviewing is the most frequently used method of assessment in psychology and consists of gathering information about an examinee by speaking directly to the examinee. A clinical interview is typically the initial approach used to gather information about a person because of the ease and depth of information that can be gathered. An interview might last anywhere from a half hour to several hours. Clinical interviews normally consist of asking for personal information about different areas of the examinee's life such as family, work, mental health, substance use, education, or legal involvement. A forensic psychologist might ask a person if he had any difficulties in school with academics, peers, or disciplinary problems. She also might ask the person about his current feelings and thoughts. Is he having any difficulty performing routine tasks such as going to work, hanging out with friends and family, or performing household chores? No matter the specific questions, there are three types of clinical interviews that fall on a continuum from unstructured to structured. In each case, there are certain advantages and disadvantages to using a single approach.

Unstructured interviews

In an **unstructured interview**, the forensic psychologist does not have a prescribed list of questions to ask but instead may have a general idea of the purpose of the evaluation or the areas to focus upon while gathering preliminary information. The forensic psychologist may simply ask about the reason for the evaluation and obtain background information that provides a context or explanation for the assessment. An unstructured

interview probably looks very similar whether it is as part of a therapeutic assessment or a forensic assessment.

Unstructured interviews are good for establishing rapport and gathering in-depth information, but because of the individual differences between psychologists they may be more inconsistent. Establishing rapport means that the psychologist and the examinee are able to get to know one another and that the psychologist is able to construct a situation in which the examinee will be open and honest. We will discuss later the reason for this practice being especially important in forensic assessments, as well as its difficulty. Nonetheless, it is important to establish rapport so that the examinee gives accurate information freely, whether it is a therapeutic assessment or a forensic assessment. Unstructured interviews also allow the interviewer to follow up on any response and ask as many additional questions as the interviewer sees as appropriate. However, unstructured interviews tend to be less reliable in the information they elicit. The questions I ask of a given examinee might be very different from the ones another psychologist asks without a common script. Furthermore, the examinee may give different answers depending on their mood and the type of rapport established by the psychologist. There is likely to be a great deal of variability in two different unstructured interviews.

Semi-structured interview

A **semi-structured interview** normally consists of predetermined questions that each interviewer follows, but also allows for some flexibility in answering those questions or additional follow-up questions. When we discuss psychopathy in Chapter 4, we will talk about the most prominently used instrument to assess psychopathy, the Psychopathy Checklist-Revised (PCL-R). One step in the administration of the PCL-R is a semi-structured interview, which is divided into general domains such as educational history, family history, occupational history, and so forth, with specific questions listed under each of those domains to focus the interview. In addition, there are suggested questions after each of these primary questions that an interviewer can ask if she chooses, based on the examinee's initial responses. However, the interviewer is not required to ask each question or any of the follow-up questions.

Semi-structured interviews may not be as helpful for establishing rapport as unstructured interviews, but they are generally more reliable across interviews and interviewers. Semi-structured interviews, like the one used with the PCL-R, do not include questions focusing on informal conversational topics such as the weather, whether the examinee had difficulty finding your office, or how he may be feeling on a given day. They are focused on getting answers to specific questions. Semi-structured interviews tend to allow for additional follow-up questions, though they are normally specified and are more limiting than in an unstructured interview. In addition, semi-structured interviews allow for some consistency in the questions asked of multiple examinees or across different interviewers. The interview I give as part of the PCL-R to my examinee will be similar, though not identical, to the interview that a colleague gives to an examinee in some other part of the country.

Structured interviews

On the far end of the interview continuum are structured interviews. **Structured interviews** are the most formal and the most rigid types of clinical interviews. They consist of specific questions that must be asked by the interviewers and the interviewer is usually not allowed to deviate from the prescribed questions. Structured interviews tend to have a specific purpose. For example, the Structured Interview of Reported Symptoms (SIRS-2) consists of 172 questions that assess whether an individual is feigning or exaggerating symptoms of a mental illness (Rogers, Sewell, & Gilliard, 2010). The examinee is told that he or she must answer each of the questions with a "yes" or "no" response, while the interviewer does not ask any follow-up questions and avoids responding to any additional comments by the examinee during the interview.

Obviously, these types of interviews are not the best if your purpose is to establish rapport. In fact, structured interviews could damage your chances of establishing rapport if one were used as an initial contact with an examinee. For example, I routinely administered a structured interview to combat veterans on a treatment unit for posttraumatic stress disorder (PTSD) to assess their PTSD symptoms. The interview normally consisted of asking them for their three most stressful experiences while they were in combat. This approach did not increase the chances of us establishing a therapeutic bond that would be useful in therapy or treatment, but that was not my purpose. My objective was to identify and validate the severity of their PTSD symptoms both for clinical and research purposes. As a result, structured interviews are normally the most useful in situations where the purpose is focused and clear but not helpful if the intent is to establish rapport. Typically, a structured interview assigns points or identifies the items an examinee endorses to use in a formal scoring procedure. As a result, consistency and reliability of administration are of the utmost importance because scores are compared across different examinees as a basis of comparison.

It should be clear that these different types of interviews are not mutually exclusive. An interviewer is not confined to conducting only one type of interview with a given examinee or even only one in a given session. Each of these approaches has their advantages and disadvantages and should be used as appropriate. If I am evaluating an examinee to see whether he would work well in our offender rehabilitation group, I may begin an initial session with an unstructured interview to briefly assess his current level of intellectual functioning and overall psychological ability. I may come away from that initial interview suspecting that he suffers from PTSD and that he would be a good candidate for a treatment study we are running for offenders who suffer from PTSD. Because there are strict criteria being used for inclusion in this treatment study, I might then perform a structured interview to assess his PTSD symptoms. I might also utilize other combinations of the three different interviews depending on my intent or the individual circumstances of the interviewee's case. Again, none of the three types of interviews is necessarily better than the other, but they each serve a different purpose. Each differs in terms of its ability to establish rapport, its allowance for follow-up questions, and the consistency or reliability of the interview itself.

Methods and Procedures: Psychological Testing

In addition to the clinical interview, the use of psychological tests is also a common method in both therapeutic and forensic assessments. Psychological testing can include a variety of tests and is particularly useful depending on the legal issue and the examinee. The most prominent types of tests used in forensic assessments tend to be personality tests, intellectual tests, neuropsychological tests, and specialized forensic tests. This is also one aspect of forensic clinical practice that separates psychologists from psychiatrists (Dattilio, Sadoff, Drogin, & Gutheil, 2011) as we mentioned in Chapter 1. Again, it is important to choose assessment approaches that have been normed on the population for which you are seeking to use them and that, as a forensic psychologist, you are aware of the levels of reliability and validity and the potential threats to them in a given situation.

Personality tests: projective versus objective

Probably the most common type of psychological test is the personality test (Archer, Buffington-Vollum, Stredny, & Handel, 2006). Personality tests are designed to measure some aspect of an examinee's normal personality or, in the extreme, his or her psychopathology or mental illness. A forensic psychologist may have to administer a personality test to assess for mental illness in cases that have a legal requirement for the presence of a mental illness; insanity, civil commitment, and some personal injury cases are appropriate examples. Psychological tests like the Minnesota Multiphasic Personality Inventory-II (MMPI-II) are used to assess an examinee's psychopathology on a variety of subscales measuring things such as depression, schizophrenia, paranoia, and antisocial characteristics.

Generally, personality tests can be divided into projective and objective tests. **Projective tests** normally consist of presenting ambiguous stimuli to individuals and recording their responses to assess an underlying pathology such as personality or psychopathology. Tests such as the Rorschach Inkblot Test and the Thematic Apperception Test (TAT) are two common projective tests used in forensic situations (Craig, 2004). In both cases the examinee is presented with an ambiguous stimulus, either an inkblot or a picture based in a particular setting, and asked for her interpretation of it. The examinee's responses are then scored to compare them to other individuals. Most projective tests are based on the assumption that an examinee's overt responses reveal internal dispositions that are not easily discovered. Projective tests offer some advantages and some disadvantages. The primary advantages of projective tests are that they reportedly assess an examinee's deepest, most unobservable psychological characteristics and may be more difficult to fake. However, many of the projective tests have been criticized because they are more difficult to standardize, administer, and score, and exhibit questionable reliability and validity (Lilienfeld, Lynn, & Lohr, 2003; Wood et al., 2010).

Objective tests are different in that they tend to be more structured and direct. They present the examinee with specific questions and ask for a specified range of responses. An objective test may include a statement like, "I don't socialize with friends as much as I used to when I was younger." The examinee may then be asked to respond

true or false or respond a scale ranging from 1 (*not at all like me*) to 7 (*very much like me*). Examples of objective tests may include tests like the MMPI-II, the Personality Assessment Inventory (PAI), or the Millon Clinical Multiaxial Inventory-III (MCMI-III). Objective tests normally allow for a relatively easy administration that produces reliable and valid results. For example, a clinical psychologist can administer an MMPI-II by sitting an examinee in front of a computer and working on other tasks while the examinee completes it. The examinee's responses can then be scored in a matter of minutes and summary information is produced for the psychologist to interpret (Butcher, 2002). In addition, objective tests tend to exhibit greater reliability and have fewer questions regarding their validity than the projective tests (Lilienfeld et al., 2003). However, objective tests require a greater level of literacy and cooperation than projective tests and tend to give a more limited view of human behavior.

Other types of psychological tests

In addition to personality, there are other areas that forensic psychologists focus their assessment and testing methods upon. Psychological tests like the Wechsler Adult Intelligence Scale-IV (WAIS-IV) focus on intellectual capabilities of an examinee. In the United States, death penalty cases are an area in which forensic psychologists may administer an intelligence test such as the WAIS-IV. Intelligence may be an issue in these cases because the United States Supreme Court has ruled that persons who suffer from mental retardation, and therefore have an intelligence quotient (IQ) below 70, are ineligible for the death penalty (*Atkins v. Virginia*, 2002). See Box 2.1 for a further explanation of *Atkins v. Virginia* in the context of intellectual assessment.

Neuropsychological tests are also a routine focus of forensic assessments. Neuropsychological tests like the Trail Making Tests A and B or neuropsychological batteries like the Luria-Nebraska are designed to assess for underlying brain deficits that may affect psychological abilities such as planning, memory, and attention. A forensic psychologist may evaluate a defendant for competency to stand trial and that assessment may include an evaluation of her long-term memory to make sure there is not an underlying impairment that explains her inability to remember the events of the crime. If long-term memory impairment exists, she may be unable to assist in her defense effectively.

Forensic assessment instruments (FAI)

In addition to the traditional types of forensic testing, there are also tests designed with forensic issues in mind—**forensic assessment instruments** (FAI). Increasingly, instruments and methods created especially to address forensic issues have been designed and are recommended for use (Heilbrun et al. 2009). These instruments can be either **specialized forensic instruments** or **forensically relevant instruments**. Specialized forensic assessment instruments "are measures that are directly relevant to a specific legal standard and reflect the focus on specific capacities,

Box 2.1. The Impact of Intelligence Testing After *Atkins v. Virginia* (2002)

Atkins v. Virginia (2002) is one of the most interesting mental health law cases of the past decade and is an excellent example of the potential impact of the law on forensic psychology. Daryl Atkins and his accomplice, William Jones, abducted Eric Nesbitt from a local convenience store in August 1996. Nesbitt only had $60 in his wallet at the time, so they forced him to withdraw an additional $200 from an ATM. Afterward, they drove him to a secluded location and shot him eight times with a semiautomatic weapon. Both men said the other had been the triggerman, but there were many inconsistencies in Atkins's version and a later cellmate reported that Atkins confessed to shooting Nesbitt. As a result, Jones was given life in prison to testify against Atkins, who was eventually convicted of murder. At the time of his original sentencing, a clinical psychologist testified that Atkins's IQ was 59 and therefore he was mentally retarded. Nonetheless, Atkins was sentenced to death. Atkins appealed the original verdict and the sentence. After a series of rulings, the Supreme Court held that it was cruel and unusual punishment to put the mentally retarded to death.

Although some may laud the Court's decision as therapeutic, the ruling and subsequent interpretations became very problematic to reconcile with the reality of the diagnosis of mental retardation. Courts and legislatures identified an IQ of 70 as the bright line for determination of mental retardation when the diagnosis is much more complicated than a single number resulting from a single test. Recent changes in the DSM-5 may reflect this understanding. A psychological diagnosis of mental retardation also includes the acknowledgment of some adaptive or functional problems. For example, a mentally retarded person must also have limitations in areas such as maintaining employment and taking care of basic hygiene in addition to a low IQ. Moreover, IQ tests are not 100% accurate or unbiased. There is a great deal of literature suggesting that they can differ among races by as much as 15 points, overall IQs may differ by 5 points because of random error, scores go up with practice, and scores generally are increasing in our society (i.e., the Flynn effect). As a result of these problems, the use of 70 as a hard and fast number has been routinely criticized by forensic psychologists. An interesting sidelight to the Atkins case is that a second jury found he was not mentally retarded, and sentenced him to death again. He was scheduled to be executed in December 2005 but his execution was stayed and the Virginia Supreme Court eventually reversed his death sentence on other procedural grounds.

abilities, or knowledge that are embodied by the law" (Otto & Heilbrun, 2002, p. 9). They may include measures designed to assess specific legal issues such as insanity or competency to stand trial. Heilbrun, Rogers, and Otto (2002) distinguished specialized forensic assessment instruments from forensically relevant instruments. They argued that forensically relevant instruments are instruments that focus on clinical issues, not legal standards, which are more common in the legal system. Instruments that assess risk of future violence and psychopathy are examples of forensically relevant instruments.

Specialized forensic instruments and forensically related instruments have an advantage over the traditional psychological tests described previously in that they are less removed from the immediate legal question. These instruments reduce the severity of any inferences that must be made by the evaluator and therefore potentially increase the reliability and validity of assessments. This idea has some intuitive appeal. For example, we have already identified the MMPI-II as a commonly used measure of personality or mental illness. This traditional clinical measure might routinely be used in insanity evaluations to assess mental illness. However, a forensic psychologist would have to infer the degree to which a person's mental illness would impair her ability to distinguish right from wrong, whereas a specialized forensic assessment instrument such as the Rogers Criminal Responsibility Assessment Scales (R-CRAS) would more directly assess the degree to which the defendant's ability was impaired in regard to the legal charges she faced. We will spend time in each specific chapter examining the different FAI.

Usage of tests among forensic psychologists Ultimately, the use of a particular test in a particular case with a particular client is at the discretion of the forensic psychologist. However, research has shown that many of the tests mentioned in this chapter are among the most frequently used tests in forensic assessments (Archer et al., 2006). The MMPI-2 is the most frequently used personality test and even the most frequently used psychological test among forensic psychologists. Its widespread use is probably a result of the vast research support for its use and the relevance of diagnosing mental illness in forensic contexts. The Wechsler intelligence scales are the most frequently used intellectual tests and the second most frequently used psychological test overall. The Rorschach is the most frequently used projective test along with the Trail Making Tests A and B, being the most frequently used neuropsychological test. The Psychopathy Checklist-Revised is the most frequently used FAI (Archer et al., 2006). The use of particular tests is important in discussions of scope of practice and in meeting admissibility criteria. One concept this text will attempt to make clear is that forensic psychologists should be aware of the research on any clinical technique used and the degree to which it is appropriate for a given client. For example, I was asked to evaluate a man who was born and had lived most of his life in Pakistan. Prior to the evaluation, I knew very little about him because of the lack of records available, though the attorney said that he spoke English well. My primary concern was whether any of the approaches and tests I normally used would be appropriate for him because all the available research had used native English speakers, largely from North America. After my research I was somewhat confident that my general protocol would be appropriate, but I was concerned about the cultural issues that would arise. How revealing would he be in the interview? Were there behavioral indications I should look for that I might misinterpret because of the cultural differences? All of these and others were very important considerations prior to conducting the evaluation and certainly in interpreting the results. The twist in the story is that although he was born in Pakistan and was educated and raised in the Middle East his entire life until coming to the United States 5 years ago, he and his siblings were educated in British schools and were forbidden to speak anything but English in the home. He could not even speak Urdu, the other official language of Pakistan in addition to English. As a result, most of

my work and concern prior to the evaluation turned out to be unnecessary but the point is still valid; it would have been inappropriate to use a test and method that had not been validated on a sample to which the client belonged. The degree to which a person fits the people on whom a given test or technique has been tested is more a professional judgment call, but one that should be made in an informed manner.

Archival Information

In addition to the use of clinical interviews and psychological tests, forensic psychologists especially must rely on **archival information** in conducting forensic assessments (Goldstein, 2003). Archival, collateral, or third-party information normally consists of information gathered from institutional records or interviews outside of the person being evaluated. Mental health records from psychiatric hospitals, probation reports, police reports, official records of criminal charges and convictions, employment records, and educational records are common sources of archival information. In addition, third-party sources such as an eyewitness, friend, or family member might also be contacted to corroborate specific information in an evaluation.

There is a greater need for archival information in a forensic assessment for two reasons. First, there is a greater need for accuracy in forensic evaluations. A forensic psychologist's conclusions will be evaluated by the legal system, and lying and faking psychological symptoms is especially relevant (Melton et al., 2007). That is not to say that therapeutic evaluations can be inaccurate. It means that not only are individuals' mental health at stake in forensic evaluations, but so might their personal freedom, their life, or even the well-being of another person. Because of the adversarial nature of our legal system (Chapter 1) and the accompanying scrutiny that an evaluation or expert testimony undergoes (Chapter 3), procedures and the final report are going to be heavily scrutinized and critiqued by a number of people. These people could range anywhere from the defendant to the judge and the opposing attorney. As a result, consulting archival and third-party information is especially important.

Another major reason that archival or third-party information is especially important is because of the high likelihood of **secondary gain** in forensic evaluations and the increased likelihood of malingering as a result (Craig, 2004; Melton et al., 2007). A forensic psychologist can expect examinees to underreport symptoms in a variety of situations such as child custody decisions or exaggerate symptoms such as in insanity or personal injury cases. In all of these cases, the examinee has something to gain, whether it is her freedom, a lesser sentence, a financial reward, or custody of a child. Secondary gain is normally considered a gain or advantage in addition to the primary goal of under- or overreporting psychological symptoms that may influence the accuracy of an examinee's self-report. It is important that a forensic psychologist be prepared for these circumstances and seek out archival and third-party information as well as be aware of different approaches to detect malingering through formal assessment.

A number of strategies that are both informal and systematic exist to detect malingering. The most common method used to detect malingering is the clinical interview (Melton et al., 2007). Several indications of potential malingering might

include exaggerated and dramatic presentation, a noticeable deliberateness and carefulness, presentation of inconsistent symptoms of a psychiatric diagnosis, inconsistency in reports, and an endorsement of only obvious symptoms of a given mental illness (Rogers, 1988). If an examinee has to pause before every answer and appears to be choosing his words very carefully, it may be an indication of deliberate behavior in order to maintain an inaccurate presentation that he thinks will benefit him. Of course, these clinical signs are not sufficient to conclude a person is minimizing or malingering, but they should serve as a beginning.

In addition to less formal indicators in a clinical interview, several instruments are commonly used to identify malingering or feigned symptoms. Several routinely used clinical measures like the MMPI-2 have established validity scales to assess distorted response patterns and research has identified specific profile patterns that suggest malingering (Bagby, Nicholson, Buis, & Bacchiochi, 2000). As mentioned previously, the SIRS-2 and the original SIRS are structured clinical interviews that have shown significant reliability and validity in identifying individuals who are feigning psychopathology (Kocsis, 2011; Rogers, Bagby, & Dickens., 1992). In addition, there are specific measures that are frequently used to assess the feigning of neuropsychological or cognitive impairment, including the Test of Memory Malingering (TOMM).

The Use of Written Reports in Forensic Assessments and Guidelines

A typical by-product of a forensic assessment is a formal report containing the procedures used and the basis for the expert's conclusion and overall findings. Although these reports can vary dramatically in terms of their length and quality, a report should follow at least four general guidelines regardless of the purpose (Melton et al., 2007). Forensic reports should separate facts from inferences, stay within the referral question, avoid information over/underkill, and minimize clinical jargon.

Forensic reports should generally seek to separate facts from inferences. It may be a substantiated fact that an examinee was convicted of theft when he was 25 years old. However, it would be an inference to say that he appeared to learn from his experience and subsequent incarceration because he did not commit any additional crimes over the next 10 years. It would be more appropriate to state that the defendant has not committed any additional crimes in the intervening years or, if true, that the examinee claims to have learned a valuable lesson from his incarceration. The examinee claiming to have learned a valuable lesson and actually having done so may be two different things and a forensic psychologist should seek to separate one from the other. Ultimately, there should be a distinction between the conclusions and the data upon which those conclusions are based.

An examiner should stay within the scope of the referral question. An examiner should address the issue that is before the court for which she has been retained. If the referral question is the risk the defendant poses upon future release, the report should address that particular question. The evaluator should avoid including extra comments that have little relevance to the referral question. For example, avoid commenting on the

dangerousness of the defendant or a potential sentence when your referral question is to assess whether he is competent to stand trial. The job of the forensic psychologist is to assist the court, and reports that don't address the referral question or include unnecessary or unwanted conclusions can be unhelpful or potentially damaging to the process.

The examiner must always make decisions about aspects to include or exclude from the report, but in general he should avoid information over/underkill. The report needs to be readily digestible by the court and the representatives of the court, most of which have had little, if any, psychological training. This process can be a delicate balancing act and there are not necessarily precise answers or an optimal report length. The forensic psychologist must include all relevant information and be clear about the basis for the report. I was once told by a more seasoned and wiser colleague (let's call him Yoda) that you need to be sure to tell the court what you know and how you know it. You need to arrive at a conclusion with sound data and make the basis for that data clear in a report. It is often important to consult with the attorney who is retaining the forensic psychologist to determine the information that should be included in the report while also being comprehensive.

A related issue is that the report should also minimize clinical jargon. Therapeutic assessments routinely include a lot of terms that are specific to psychological conceptualizations of particular issues, but as mentioned previously, psychologists are not the only professionals reading these reports. If a forensic psychologist is to truly assist the court, she must minimize language that will be confusing or unclear to legal professionals. Petrella and Poythress (1983) conducted a study evaluating the use of clinical jargon and found that judges and lawyers generally found the following terms and phrases unclear and confusing: delusional ideation; affect; neologisms; loosening of associations; flight of ideas; blocking; his paranoid ideation is nonspecific, completely unsystematized; oriented to time, place, and person; lability; loose associations and tangentiality; flat affect; grandiosity; personality deficit; hysterical amnesia; lack of registration amnesia; and psychotic mentation (see Table 2.2 for definitions of some of these terms). These terms may be common in psychological settings but would fail to communicate properly in a legal context.

Some research has addressed the nature of forensic reports. For example, Grisso (2010) conducted an examination of 62 forensic reports submitted to the American Board of Forensic Psychology (ABFP) that were not approved for use in the final step for becoming a diplomate in forensic psychology to assess the types of errors made in forensic reports. Grisso identified a list of the 10 most frequently identified faults in these forensic reports: opinions without sufficient explanations (53%), forensic purpose unclear (53%), organizational problems because information was presented in a disorganized manner (36%), irrelevant data or opinions for the referral question (31%), failure to consider alternative hypotheses (e.g., malingering or diagnosis) (30%), inadequate data to form an opinion or base a conclusion (28%), data and interpretation mixed in report (26%), overreliance on a single source of data (22%), language problems such as jargon, bias, or extraneous comments (19%), and improper use of tests (19%). It should be clear that many of these most frequently identified faults are addressed by the four general guidelines identified above and that even forensic psychologists applying for recognition

Table 2.2. Defining Some of the Clinical Jargon

Jargon word(s)	Definition
Affect	Another name for emotion
Delusional ideation	False beliefs
Flat affect	An absence of emotional expression
Flight of ideas	Progression through a series of ideas that is usually at high speed
Grandiosity	An inflated view of one's abilities, self-worth, or importance
Lability	Refers to constantly changing, usually inappropriate, emotion
Loose associations	A lack of a connection from one thought to another
Neologisms	Newly created words that are often a symptom of schizophrenia
Oriented to time, place, and person	Being able to identify the current time, your current location, and who you are

Source: Based on Petrella & Poythress (1983)

as board certified in their area of specialization do not always address them. Overall, the intent of these four guidelines and Grisso's findings are to improve the forensic psychologist's ability to assist the courts in making their legal decisions, the very purpose of forensic assessment.

Treatment in Forensic Contexts

A second major task in which forensic psychologists routinely engage is the treatment of individuals in forensic settings (Otto & Heilbrun, 2002). As the previous discussion of forensic assessment suggests, forensic assessment has been a more central part of forensic psychology in the past than treatment (Borum & Otto, 2000). This lack of emphasis has been true despite the fact that the landmark case, *Estelle v. Gamble* (1976), identified a constitutional right to medical care for prisoners. The right has been clarified to extend to mental health care. Moreover, recent evidence (see Box 2.2) suggests that treatment approaches based on the most effective treatment model, Risk-Need-Responsivity, are not more costly (Romani, Morgan, Gross, & McDonald, 2012). The overemphasis on assessment in specialized offender populations may be partially based on the idea that many psychologists viewed treatment uniform and that there was not much unique to forensic settings. If a psychologist used a certain approach to treat a mental illness outside of a forensic setting, he could use that same approach inside a forensic setting. In addition, forensic psychologists typically engage in treatment that does not relate to a specific legal question. There is certainly a rich area of true forensic treatment, such as restoration of competency and civil commitment, in which an improvement in an individual's psychological state does impact the legal question. A person may be found incompetent to stand trial because he suffers from schizophrenia

Box 2.2. A Focus on Research: The Cost of Offender Treatment

Romani, Morgan, Gross, and McDonald (2012) conducted a novel study. Typically treatment studies focus on the effectiveness of a given intervention or model, but their study examined the financial impact of the approach typically seen as the most appropriate for offender populations, Risk-Need-Responsivity. As all facets of not only forensic psychology but society in general are forced to justify their effectiveness and their cost-effectiveness in a challenging economic environment, their study was very timely. Romani et al. focused on the studies that Andrews, Zinger, Hoge and Bonta (1990) used in their seminal meta-analysis on the effectiveness of treatment correctional services because they had already identified the different treatment approaches and the corresponding theoretical models, RNR, non-RNR interventions, and traditional criminal sanctions. Overall, they found there was no difference in the cost of the three approaches. However, when length of time was factored in, the non-RNR approaches were significantly more expensive because offenders spent more time in the programs, almost 5 months longer than traditional criminal sanctions and 2 months longer than the RNR approaches. These differences average out to $2 per 1% reduction in criminal recidivism for RNR approaches, $19 for non-RNR approaches, and $40 per for traditional sanctions. Overall, the results suggest treatments that are effective fiscally and therapeutically are available.

However, there were potential limitations with the study. The studies utilized were dated because they came from a study that had been published over 20 years ago and publication ages ranged from 1950 through 1989. Furthermore, it is not always perfectly clear from original research articles the degree to which a given treatment approach actually adhered to the principles of RNR. In fact, Romani et al. said that some of the non-RNR and some of the traditional correctional interventions appeared to exhibit some aspects of RNR in their description. There usually is a difference between the best intentions and the degree to which a treatment is applied appropriately to the actual offenders or clients. Finally, Romani et al. were not able to gather the actual costs incurred in each and every study they reviewed and therefore had to estimate the costs of some treatments.

and is unable to tell the difference between reality and fantasy, much less assist in his own defense. If he is treated for his schizophrenia and the symptoms remit, then he may be competent and can stand trial. However, forensic psychologists commonly engage in treatment after an individual has been adjudicated and is incarcerated or institutionalized. Much treatment occurs when a person begins to exhibit psychological problems while in a correctional institution such as a prison or jail. A criminal offender who has already been sentenced is not actively involved in the courts system, besides possible appeals or other possible issues such as a sexually violent predator designation, because he has been convicted. Nonetheless, there is a reason to treat these offenders. If they are treated or successfully rehabilitated, they are less likely to come into contact with the law when released. In addition, many forensic psychologists performing forensic assessments are also working in prisons and forensic hospitals treating offenders.

One distinction we have alluded to in the prior paragraph is the difference between forensic psychology and correctional psychology. **Correctional psychology** refers to the application of clinical psychology to a prison or correctional setting absent of any direct legal application. For example, a correctional psychologist may treat mental illness in an incarcerated offender in order to relieve his suffering, make him more manageable in the prison environment, and rehabilitate him for his return to society. Such a task may not have any direct legal application. However, if that same offender committed a sexual offense and is facing commitment under a Sexually Violent Predator statute (see Chapter 6), there is now a direct legal question at issue. It is this latter task that tends to be seen as forensic and the former task as correctional. However, these lines are often blurred in the actual practice of psychology and many distinctions between forensic and correctional psychology are unimportant. As a result, our treatment discussion will focus on treatment of offenders that may be considered more correctional, while we will save much of the discussion of pure forensic treatment when it is relevant to specific chapters. However, the reader should keep in mind that there is often a distinction between treatment of psychological difficulties that relate to a specific legal issue and treatment that is intended to rehabilitate criminal offenders so that they are less likely to commit future offenses when released from jail or prison.

Who Are We Treating?

Most people think of offenders as one large homogeneous group. However, offenders are a vastly heterogeneous group comprised of a variety of offenses types and the people who perpetrated them. Offender groups may include nonviolent offenders who are incarcerated for crimes such as theft, destruction of property, or even for more white-collar crimes such as embezzlement. They include violent offenders who have a history of impulsive and aggressive behavior. Even violent offenders are diverse in that they may include individuals who perpetrate domestic violence or sexual violence. A great number of offenders suffer from substance abuse problems that may not be the basis for their criminal conviction but nonetheless serve as an important factor in their antisocial behavior. Although most offenders are men, research also has revealed that female offenders have a variety of mental health needs (McPhail, Falvo, & Burker, 2012). Furthermore, treatment interventions for juvenile delinquency exist and increasingly exhibit positive outcomes (Vetere, 2010). Mentally disordered offenders overlap with all of the previous groups but even this group includes offenders with a variety of needs. Mentally disordered offenders include individuals found Not Guilty by Reason of Insanity, Incompetent to Stand Trial, Mentally Disordered Sex Offenders, and simply mentally ill offenders.

Prevalence estimates of mental illnesses vary widely—anywhere from less than 5% to over 50%, depending of the definition of mental illness and the nature of the correctional setting (Corrado, Cohen, Hart, & Roesch, 2000). However, the research clearly suggests that incarcerated offenders suffer from a variety of mental illnesses. One study examining offenders across several different regions of the United States identified that

15.2% of newly admitted offenders required mental health services for a serious mental illness (Magaletta, Diamond, Faust, Daggett, & Camp, 2009). Moreover, almost 10% of the sample had experienced a prior psychiatric hospitalization. In addition to serious mental illnesses, substance abuse diagnoses may be prevalent among 50% of incarcerated offenders (Arboleda-Florez et al., 1995) and Fazel and Danesh's (2002) review of over 60 studies found that 47% of men were diagnosed with Antisocial Personality Disorder. In yet another study, researchers found more than half of incarcerated women incarcerated were on psychotropic medication (O'Brien, Mortimer, Singleton, Meltzer, & Goodman, 2003). No matter the precise estimates, it is clear that mental illness is a significant issue among incarcerated offenders and correctional facilities treat more mentally ill individuals than do psychiatric facilities today.

The reason for the prevalence of mental illnesses among offenders is probably multifaceted. There has long been a discussion of the criminalization of the mentally ill (Teplin, 2001). During the 1970s, as the inpatient mental health care population decreased by over 60%, the prison population correspondingly increased by a similar amount (see Mobley, 1999; Teplin, 1983, 1984). Furthermore, the mentally ill have a significantly greater chance of being arrested than the non-mentally ill for similar offenses (Teplin, McClelland, Abram, & Weiner, 2005). This trend occurs despite the findings that the mentally ill are much more likely to be a victim of violence than a perpetrator. Choe, Teplin and Abram (2008) found that 2% to 13% of outpatients had perpetrated violence in the past 6 months to 3 years but that 20% to 34% had been victimized violently. To illustrate this point, assume the police are called to a local park after hours. They find a man sleeping on a park bench, but he seems responsive and sober. They may simply ask that individual to leave and check back to make sure he has not returned. However, if that same man talks about hearing voices that directed him to the park to sleep, the police may take the man to jail for his own protection as well as to protect society. In both instances, the individuals may have been trespassing, yet the individual who may exhibit a mental health issue is incarcerated.

In addition to the possible criminalization of the mentally ill accounting for the rise in prevalence rates, the very nature of the prison experience may be a factor. Dvoskin and Spiers (2004) pointed out there are five important stressors that are likely to impact one's psychological well-being (i.e., extreme noise, heightened temperature, elevated levels of fear, filth, and overcrowding) and prison is one environment in which all five of these factors are present. Other sources of stress include disciplinary infractions and physical and sexual victimization (Bewley & Morgan, 2011). Of course, many may point out that these poor conditions are appropriate given that the offenders have broken the law. However, this issue only highlights that the legal system and mental health care system have different purposes (Howells, Day, & Thomas-Peter, 2004). The goal of the legal system is to punish and the goal of mental health is to rehabilitate the offender. It is in this environment that potentially vulnerable individuals are incarcerated.

The vulnerability of this population provides an additional reason for the potentially elevated prevalence rates of mental illness. It has been well established that individuals

from lower socioeconomic areas are at increased risk for many mental illnesses (Glover, Leese, & McCrone, 1999). This increased risk not only comes from the additional environmental and economic resource problems they may experience but also the lack of education about mental health and the lack of available mental health resources. Accordingly, individuals from lower socioeconomic backgrounds are more likely to be incarcerated. These findings inevitably play a role in the prevalence of mental illness among offenders.

Types of Treatment

Treatment in correctional and forensic settings can take on many forms. Mobley (2006) identified a comprehensive model of offender treatment that includes four types of treatment: management, maintenance, outpatient programs, and special programs. Although these types of treatment are presented as distinct for conceptual purposes, they also overlap and are interdependent on one another.

Treatment focused on *management* seeks to reduce and eliminate acute crises. Acute crises are short-term but potentially severe and may include self-mutilation, suicidal gestures, general violence, or acute displays of psychotic or impulsive psychopathology. Routinely, precipitating environmental stressors originating either from within or outside the prison environment that lead to these crises. The intervention strategies typically include resolving the immediate crisis, providing for the immediate safety needs of the offender or others around him, and establishing a plan to reduce future recurrences (Mobley, 2006).

Maintenance, on the other hand, focuses on chronic mental health issues that are not likely to be resolved completely in the prison or jail context. Maintenance usually occurs in situations in which the offender is suffering from a serious mental illness, developmental disorder, or severe cognitive disorder. Treatment normally focuses on stabilization through medication and an effort to maintain a consistent environment in a setting that tends to resist individualized interventions. Furthermore, research has found that these programs can be effective in managing misconduct (French & Gendreau, 2006).

Although outpatient therapy is not a routine aspect of offender care, there are increasing efforts to recognize that continued supervision of those at risk is important (Roskes, Feldman, & Baerga, 2003). According to Mobley (2006), outpatient treatment normally focuses on adjustment and coping problems, anxiety and depression that are the result of the daily living. The focus in these instances is on identifying effective coping strategies, eliminating **cognitive distortions**, and general symptom management.

The final type of treatment increasingly available to forensic populations is the use of specialized programs (Mobley, 2006). These programs usually focus on a specific issue or area such as substance abuse, anger control, personality disorders, sexual offending, or criminal thinking errors. They also offer the opportunity of intensive and focused intervention and research has supported their use (see Walters, 2003a, for a program focused on criminal thinking). However, these programs also can be expensive and staff-intensive (Mobley, 2006).

Success of Offender Programs

Although it is clear that there are and have been well-established treatments, questions still remain. First, is it possible to successfully treat offenders? Second, if it is possible to treat offenders, are there treatment approaches that are more successful than others? Finally, are these approaches equally successful for all offenders, or are there some offenders who are untreatable? Furthermore, in examining the effectiveness or success of these programs researchers have focused on a number of outcome variables. Studies have focused on general criminal behavior, violent reoffenses, institutional misconduct, rehospitalization, symptom severity, level of social contact, occupational stability, or self-reported adjustment (Harris & Rice, 1997). Although much of the research tends to focus on recidivism to some extent because of the objective nature of the variable and its obvious importance from a policy standpoint, it is still important to pay attention to the manner in which success or effectiveness is defined in evaluating this research.

The history of offender treatment is marked by a variety of twist and turns. During the 1960s mental health care began to make some inroads into jails and prisons despite a lack of evidence for the effectiveness of offender rehabilitation (Gendreau, 1996). However, in 1974 Robert Martinson concluded that offender rehabilitation was largely ineffective after a review of the research (Martinson, 1974). The phrase *nothing works* became attributed to him and became popular among the policymakers in the United States so that efforts at rehabilitation were scaled back (Cullen & Gendreau, 1989). It was not until the late 1980s and early 1990s that optimism was restored with a number of additional reviews and meta-analytic studies of the literature (Gendreau, 1996) with more recent meta-analyses further supporting offender rehabilitation as effective (e.g., Dowden & Andrews, 2007; Dowden, Antonowicz, & Andrews, 2003; Martin, Dorken, Wamboldt, & Wooten, 2012; Morgan et al., 2012). Antonowicz and Ross (1994) made an important conclusion when they stated in their earlier review that "a growing body of research literature attests to the fact that some rehabilitation programs are successful with some offenders when applied by some staff" (p. 97), and therefore highlighted the difficulty in current efforts. Although offender rehabilitation can be effective when properly designed and administered, the previously described conflict between the criminal justice and mental health systems can impede progress. Nonetheless, the available evidence seems to suggest that offenders can be treated effectively.

Successful Offender Programs

Since it is possible to treat offenders, are there treatment approaches that are more successful? In fact, the research has revealed a number of characteristics that are relevant to the success of treatment programs. Successful programs should present a sound conceptual basis that includes behavioral and cognitive components (Landenberger & Lipsey, 2005). A sound conceptual basis means that programs should have a particular theoretical basis that leads to a more structured and focused delivery of treatment. It provides the mental health experts with a guide to follow and an indication of the techniques that should be applied. Specifically, most reviews of the literature recommend a cognitive-behavioral

approach that focuses on behavior and acquiring life skills along with correcting the attitudes and beliefs that lead to antisocial behavior (Landenberger & Lipsey, 2005). Antonowicz and Ross (1994**)** found that 75% of successful programs were cognitive behavioral whereas only 38% of unsuccessful programs were cognitive behavioral.

The most widely recognized comprehensive intervention is probably the Risk-Needs-Responsivity (RNR) by Don Andrews and colleagues (Bewley & Morgan, 2011). The theory emphasizes focusing on the three areas comprising its name. The *risk* factor focuses on treating those offenders who are at greatest risk for reoffending. This entails assessing those offenders so that their risk level can be ascertained. The principle is based on the idea that the high-risk offenders are most likely to benefit from treatment and the low-risk offenders are unlikely to benefit from treatment (Andrews & Bonta, 2006).

Programs should target *needs*, specifically **criminogenic needs**, or those factors that are known to lead to future recidivism. Criminogenic needs are the goals that offenders have or the needs they fulfill when committing crimes. These needs typically include antisocial attitudes, substance abuse and dependence, and promoting prosocial behaviors (Dowden & Andrews, 2000). By addressing these needs it decreases the chances that offenders are likely to turn to crime and increases the chances that they are more likely to seek out noncriminal alternatives to these antisocial behaviors. For example, 90% of effective programs target criminogenic needs (Antonowicz & Ross, 1994).

Programs should match offenders to the appropriate type of treatment with the appropriate staff (Gendreau, 1996). This approach is often called the **responsivity** principle as the expectation is that effective interventions should be responsive to the characteristics of the people who are being treated and that these characteristics can be used to arrive at the best possible outcomes. One study examined the impact of program characteristics that suggested implementation of the responsivity principle and found that 80% of successful programs exhibited these characteristics (Antonowicz & Ross, 1994).

We even know the characteristics of programs that fail to rehabilitate offenders and that may even increase the likelihood of them reoffending. For example, Gendreau (1996) mentioned four characteristics of unsuccessful programs. He described programs that use traditional psychoanalytic and client-centered therapeutic approaches, sociological strategies that focus on particular subcultures, retributive programs that focus on punishing the offender (e.g., boot camps), and any program that directs efforts toward noncriminogenic needs and that did not address the multiple causes of offending as ineffective.

Although we may know the characteristics of effective programs, it remains unclear the degree to which institutions are implementing these principles. Bewley and Morgan (2011) surveyed a national sample of mental health professionals in correctional settings serving mentally ill offenders and found some interesting results. Only 43.9% of the participants identified cognitive-behavioral therapy (CBT) as their theoretical orientation. Of course, this finding does not mean that CBT was not being implemented at these facilities, only that it was not endorsed as the primary theoretical orientation by these clinicians. Furthermore, only 15.7% of the participants incorporated all of the RNR principles into their treatment approaches. Bewley and Morgan (2011) suggest

this low endorsement rate may be the result of traditional clinical training focusing on the treatment of mental illness and not the rehabilitative aspects of prison. Finally, they identified six factors that were most important to the mental health service goals: (1) mental illness recovery, (2) emotions management, (3) institutional functioning, (4) re-entry, (5) risk-need, and (6) personal-growth. These form a potential framework for clinicians designing programs that address both criminal justice and mental health issues.

A review of the literature gives clear answers to the first two questions raised. The treatment literature increasingly supports the notion that a variety of types of offenders, whether they are mentally disordered, general offenders or juvenile offenders can be successfully treated or rehabilitated, despite some of the inherent conflicts between the mental health and criminal justice system. Although not all treatments and staff are created equal, we have evidence regarding the necessary components of successful treatment approaches. However, the final question as to whether these programs are effective with all offenders has not been answered. Unfortunately, this question will not be fully addressed here, but it will be addressed in future chapters as we discuss interventions for specific offenders and in regard to specific legal questions. For now, the focus will shift to the final area of practice in forensic psychology—consultation.

Forensic Consultation

Forensic consultation is an area of forensic practice that is poorly understood and is examined even less than forensic assessment or forensic treatment in the scholarly literature. This trend is interesting, as the broader field of trial consulting is a multimillion-dollar business (Strier, 1999). The term *trial consulting* often refers to aspects of psychology that are more frequently performed by social psychologists, not clinical psychologists. Trial consulting more traditionally applies to tasks such as conducting surveys for change of venue motions, assistance with jury selection, and preparing witnesses to testify (Boccaccini, 2002; Myers & Arena, 2001). In keeping with the focus on clinical aspects of forensic psychology this section will not focus on these aspects but instead focus only on forensic consultation as it relates to clinical psychology.

As Drogin and Barrett (2007, p. 466) state: "Forensic psychologists often view consultation as little more than a streamlined or segmented approach to their familiar, customary activities: for example, performing an evaluation without having to testify, reviewing a report without having to compose one, locating a specialized expert without having to be one." However, the distinction is not quite that simple. In Chapter 3, we will extensively cover the different ethical issues involved in being an expert or an expert witness. Generally though, an expert witness is expected to remain objective, unbiased, and avoid the adversarial nature of the legal system. However, consultants work as advocates. They are actively working for one side over the opposing side. A forensic psychologist who is asked to advocate for a certain position by identifying those aspects of the literature that support a position knowing that an attorney will seek to exploit only those aspects may experience a lack of professional familiarity with this role and consider the ethical implications of their expertise being misused (Shapiro,

2002). As a result, experts have argued very strongly against serving as both a consultant and a testifying expert witness in the same case (Drogin & Barrett, 2007). However, performing forensic consultation is not inherently unethical and these issues can be avoided. You should keep these issues in mind as we discuss consultation and expert testimony in Chapter 3 and remember that a forensic psychologist's role as a consultant is very different from her role as a testifying expert.

Much of the work of the forensic expert focuses on assisting attorneys on a variety of trial-related issues. One task may involve identifying relevant experts to testify in the case. In these cases the forensic consultant should become familiar with all aspects of the case in order to be able to give the most comprehensive and useful advice. An attorney may ask a forensic psychologist for information on where to find a psychologist who can testify about the impact of sexual abuse on a child. Moreover, an attorney may not even be aware that a psychological expert could be useful in a given situation or of the type of mental health expert that would be the most useful in a particular case (Drogin & Barrett, 2007). Sometimes consultation consists of educating an attorney on the research in a given area (Gottlieb, 2000). The consultant may be aware of the different accrediting organizations as well as be able to review more competently the past work of potential experts to recommend the best one. An attorney does not have the time to develop this level of knowledge and thereby the forensic consultant can be very useful.

Another common avenue for consultants is to evaluate the testimony or work product of an opposing expert (Singer & Nievod, 1987). A forensic psychologist may review an opposing expert's report to evaluate whether it appears the expert has administered the psychological tests properly, whether the data support the conclusions of the report, and whether the report addresses all of the statutory requirements for the particular civil or criminal issue. An attorney may use this information to cross-examine an opposing expert and identify any errors or questionable issues in a report (Drogin & Barrett, 2007). This task may also involve review of any documentation produced by the expert for the case and anything else the expert has written or stated publicly on the issue. These searches may provide contradictory statements in relevant cases that can be used to discredit the testifying expert.

Forensic psychologists are increasingly utilized in issues involving family law (Kaufman, 2011). As Kaufman (2011) notes, an attorney may be representing a father in a custody dispute in which the father continues to engage in behavior that is against his best interests. He may argue with the psychologist performing the custody evaluation or send heated emails to his soon-to-be ex-wife. The attorney may need assistance from a forensic psychologist to explain the impact of his behavior on the custody evaluation and support him through the process. This type of consultation is beyond the more traditional assistance with trial strategy and document review (e.g., Austin, Dale, Kirkpatrick, & Flens, 2011) but is yet another way that forensic psychologists may act as consultants.

A final area where forensic psychologists are increasingly being used as consultants relates to policy issues. Many government or independent agencies are using forensic psychologists to help them form policy initiatives or evaluate already existing policy.

For example, Norris (2003) explained the role forensic consultants played in reshaping the Catholic Church's policies for the protection of children after the sexual abuse crisis. The Catholic Church formed a commission that was charged with arriving at a set of policies that would protect children from future sexual abuse. Forensic consultants were involved in formulating the new policies and programs and the training of Church officials to implement and respond according to the policies. This example is just one in which forensic consultants can use their expertise outside of the more traditional roles of assessment and treatment.

In addition to these roles, forensic psychologists are used to consult in numerous other ways outside of testifying as expert witnesses themselves. It should be reiterated that serving as a forensic consultant is a role outside of the normal training that forensic psychologists routinely receive and one that involves potential ethical issues that may conflict with the traditional objective scientific approach taken when serving as an expert. Nonetheless, it is likely that forensic psychologists will increasingly serve as consultants in these traditional roles as well as a host of yet unrecognized roles.

Reflection and Review

1. How do forensic assessments differ from therapeutic assessments?
2. Why are reliability and validity important to a forensic psychologist?
3. What are some of the differences between different interview approaches?
4. Why is converging evidence important?
5. Why is secondary gain a bigger issue in forensic assessments than therapeutic assessment?
6. What are differences between management, maintenance, outpatient, and specialized programs in the treatment of offenders?
7. Why do you think the RNR is the model most supported by the research for the treatment of offenders?
8. How does consultation differ from the other two major forensic practice areas?
9. What ethical considerations should be thought about in relation to consultation?

Key Terms

archival information
cognitive distortions
correctional psychology
criminogenic needs
forensic assessment instruments
forensically relevant instruments
objective tests
projective tests
reliability
responsivity
scope of practice
secondary gain
semi-structured interview
specialized forensic instruments
structured interviews
therapeutic assessment
unstructured interview
validity

Further Readings

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3 Expert Testimony and the Role of an Expert

Chapter Objectives

1. Discuss the major legal cases addressing admissibility of expert testimony
2. Identify the major criticisms of expert witnesses
3. Describe the ethical issues confronting forensic psychologists

The practice of forensic psychology frequently ends with the forensic psychologist testifying as an expert witness. As expert witnesses, psychologists are able to assist the law directly by informing the courts of psychological findings and their application to a particular legal question. However, it is important to remember that forensic psychologists are merely assisting the legal system. The legal system, judges in particular, is appropriately resistant to legal authority being usurped or replaced by psychological evidence (Ogloff & Cronshaw, 2001). The purpose of the forensic psychologist as an expert witness is not to replace the decision-making ability of the court, but to assist it. It is also important to realize that forensic psychologists usually serve as experts without testifying in court, but much of our discussion in this chapter applies to both the testifying expert and the non-testifying expert.

By agreeing to enter into the courtroom, psychologists face several important challenges that they otherwise are not exposed to in their routine clinical practice (Brodsky, Caputo, & Domino, 2002). The adversarial nature of the legal system itself is a challenge for forensic psychologists, who typically practice in environments in which there is collegiality and open discussion of ideas. However, the adversarial nature of the courtroom can make it very clear that ideas and conclusions will not be discussed but instead critiqued in a competitive atmosphere. Furthermore, this criticism is conducted in a very public place in which there is little support for the testifying expert. An expert does not have the luxury of calling a time-out or hitting the reset button while on the witness

stand. The expert is truly alone. This entire experience takes place in a setting with which the expert is largely unfamiliar, another reason that expert testimony has been called the most frightening professional experience in psychology (Brodsky et al., 2002).

The increasing use of mental health practitioners as expert witnesses in the United States, Canada, and in many places around the world (Knapp & VandeCreek, 2001; Saunders, 2001) suggests they have a significant impact on the legal system. Hess (2006b) argues that as our society becomes more complicated and knowledge expands at an exponential rate, there is an even greater need for experts. In fact, he suggests that neglecting to use an expert in a case could constitute a professional failure on the part of an attorney (Hess, 2006b). However, the truth is that the impact of expert testimony on juror decision making is not completely clear (Nietzel, McCarthy, & Kern, 1999). Nietzel and colleagues conducted a meta-analysis of 22 published studies examining the impact of expert testimony across a variety of different cases including such diverse topics as child abuse, eyewitness identification, insanity, battered woman or rape trauma syndrome evidence, hypnosis, and polygraph evidence. A **meta-analysis** is an approach in which the available studies are statistically combined to ask and answer questions that are more difficult, if not impossible, to answer with only a single study. This statistical approach helps supplement the traditional method of summarizing an area of research that has consisted of reading the available literature and coming to a conclusion based on rational consideration of the different studies. Nietzel et al. (1999) found only a modest impact of expert testimony across these different types of cases of expert testimony. Nonetheless, there is no indication that the courts are tired of the testimony of forensic psychologists or will be discontinuing it. In fact, a Missouri Court of Appeals case even found that failure to call a psychologist during the sentencing phase of a case regarding a defendant's mental disability constituted ineffective counsel (*Radmer v. State*, 2012), potentially not only encouraging but requiring the use of experts in certain situations.

However, the vast majority of forensic work does not culminate in expert testimony. Consultation work by its very nature does not result in testimony as an objective expert. Forensic assessments and treatment also do not tend to conclude in courtroom testimony, because the vast majority of cases are settled before trial. Nonetheless, it is still important to focus special attention on testifying experts because much of the public's view of forensic psychology is based on these public displays of forensic work. In addition, many of the issues I will discuss in relation to expert testimony such as ethical concerns and biases are true for any forensic work in which the forensic psychologist is serving as an objective expert, whether it results in courtroom testimony or not. Finally, because of the scrutiny involved in testifying as an expert, forensic psychology likely has improved its clinical and research methodology in order to defend conclusions in court based on the available literature.

History of the Expert Witness

Psychologists have not always widely testified as experts. Opinions vary, but Gravitz (1995) suggests that one of the first instances of expert testimony in the United States

that could be regarded as falling under the general umbrella of forensic psychology or psychiatry occurred in a murder trial in 1846. John Johnson was tried for the murder of Betsey Bolt as part of a plan to cover up a previous sexual assault of Mrs. Bolt by Johnson. An expert, Amariah Brigman, testified extensively on the mental health status of one of the witnesses, who had been a patient in a psychiatric hospital. However, most of the early attempts at encouraging the use of psychological principles in the legal system occurred before the field of clinical psychology was formally established and therefore concerned areas such as perception and cognition (e.g., eyewitness identification). These early attempts were aided by significant figures such as Hugo Munsterberg (Chapter 1) and his book *On the Witness Stand* (1908), in which he encouraged the use of a variety of psychological findings and methods to aid the court, including some clinically related areas such as criminal behavior. Although his early claims regarding the ability of psychology to make a difference in the courtroom may have been overly optimistic (Benjamin, 2006), Munsterberg did encourage consideration of the possibility despite early critiques by legal scholars such as John Wigmore (see Box 3.1 for discussion of the Wigmore critique of Munsterberg).

The professional status of clinical psychologists in the early part of the twentieth century made it unlikely that psychologists would flood courtrooms. During the infancy of clinical psychology, clinical psychologists were largely seen as administrators of psychological tests and certainly secondary to psychiatrists in the mental health field. As a result, psychiatrists were the only ones consistently able to testify in legal matters (Ewing, 2003). This practice changed with *Jenkins v. United States* (1962). Jenkins, the defendant, was charged with assault and breaking and entering a house. At the trial several psychologists and psychiatrists testified for the defendant regarding his sanity. The trial judge instructed the jury to ignore the psychological testimony about a schizophrenia diagnosis of the defendant because they were not qualified to diagnose mental illness. The majority opinion in the DC Circuit Court of Appeals, as authored by Judge David Bazelon, who will be mentioned in Chapter 9 (Insanity), reasoned that because of their significant training and expertise, clinical psychologists should not be barred from testifying on mental health issues as a matter of law (Ewing, 2003). As Ewing (2003) writes in regard to *Jenkins*, "its importance to the history of forensic psychology cannot be underestimated" (p. 58). Without the decision in *Jenkins*, it is unlikely that we would be experiencing the prolific growth in forensic psychology that has occurred over the past 40 years.

Admissibility of Expert Testimony

In order for psychologists to testify in a trial, their testimony must be legally permissible or admitted by a judge. The admissibility of scientific expert testimony has been of increasing interest over the past several decades, as indicated by some significant cases decided by the respective Supreme Courts of the United States and Canada (see *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 1993; *Regina v. Mohan*, 1994). However, the admissibility of scientific testimony and psychological testimony can be traced back

Box 3.1. Discussion of Munsterberg and Wigmore Controversy

Hugo Munsterberg was one of the most eminent psychologists of the early 1900s. He became director of the first psychological laboratory in the United States, originally established at Harvard, and one of the first presidents of the American Psychological Association in 1898. Generally he is recognized as the father not only of forensic psychology but of the entire field of applied psychology.

A figure equal, if not superior, to Munsterberg in his field of the law was John Henry Wigmore. Dean Wigmore was a Harvard-educated dean of Northwestern Law School and potentially the most important legal scholar of his time. Wigmore agreed with much of the sentiment Munsterberg expressed in *On the Witness Stand* and had even lectured on such topics as the fallibility of eyewitness testimony before *the book* was published. Nonetheless, Wigmore believed that many of Munsterberg's claims were excessive and without foundation in the psychological research. Wigmore carried out his response to Munsterberg in a creatively fashioned article in a 1909 issue of the *Illinois Law Review*. Wigmore framed his response as a fictional trial in which a character "Muensterberg" was placed on trial for libeling the legal profession.

Most accounts of the mock trial have alluded to it being similar to other historical events such as Custer's last stand with Munsterberg serving in the role of Custer (Doyle, 2005). Wigmore was able to refute many of Munsterberg's claims about psychology's application to the law. Though his fictional account left Munsterberg recoiling and some psychological scholars claimed that it left psychology completely disregarded in the eyes of the law (Brigham, 1999), it also provided one of the first opportunities for psychology to learn from the legal community. Moreover, Wigmore is often described as one of the biggest, if not the biggest, proponents of psychology informing the legal system.

much further to cases and principles that continue to be relevant today. It is also extremely important for forensic psychologists to be aware of the legal standards for the admissibility of their testimony because it has a direct bearing on the methods and techniques they utilize in their practice. Even though forensic psychologists are unlikely to testify in the majority of their cases, they must be prepared for the potential in every case.

Frye Standard

In the United States, the relevant standard across most states and the federal government prior to *Daubert* was the *Frye* standard. In *Frye v. United States* (1923), the DC Circuit Court of Appeals stated that "while courts will go a long way in admitting expert testimony deduced from a well-recognized scientific principle or discovery, the thing from which the deduction is made must be sufficiently established to have gained general acceptance in the particular field it belongs" (p. 1014). Hence, the sole basis for allowing scientific experts to testify under the *Frye* test was that of *general acceptance*. If a scientific procedure or theory was generally accepted by a particular scientific field, the expert

was allowed to testify. If the specific field did not accept the theory or procedure as accurate, the expert was not allowed to testify, theoretically. In *Frye*, for example, the issue was the admissibility of expert testimony regarding a polygraph (i.e., lie detector). The court concluded that the scientific field did not generally accept the polygraph as reliable or valid, so such testimony was not admitted into court. Polygraph experts continue to be excluded from testifying today under most circumstances. The *Frye* test was easily administered by the courts since it required minimal scientific sophistication from judges (Faigman, Porter, & Saks, 1994).

The courts also balance the probative value of the evidence against the prejudicial consequences of admitting the evidence (Taslitz, 1995). The **probative value** means that a piece of information helps prove a particular point or is useful in deciding an issue before the court. **Prejudicial** refers to the potential damage or bias a piece of evidence or testimony may cause. All evidence offered in court is both probative and prejudicial. As a result, a balancing test means that the information an expert conveys must be more beneficial (i.e., more probative) than any prejudice or bias that it might introduce into the minds of the judge or jury, or it will not be admitted into court. For example, past crimes such as a previous arrest for murder are generally not admissible in a criminal trial. The reason behind the practice is threefold: such information would bias juries against a defendant unreasonably, would be too prejudicial, and would provide little, if any, probative value in deciding if the defendant was guilty of the current crime. Expert testimony must meet the same burden of being more beneficial than it is biasing.

In addition, the federal courts have their own Federal Rules of Evidence (FRE), several of which address expert testimony directly. FRE 702 states that any expert testimony must be based on sufficient data, reliable principles and methods, and the reliable application of those principles and methods to the case. FRE 703 directly addresses the data relied upon by the expert in order to form his opinion and states that testimony can be admitted if the principles and methods are reasonably relied upon by others in the field. Ultimately, these legal foundations have encouraged forensic psychology to seek out a higher standard and be mindful of the empirical basis for conclusions made as a forensic psychologist. As a wise and experienced forensic colleague said, "what do you know and how do you know it?" Forensic psychologists should be transparent in their methods and foundations to formulate their conclusions.

Daubert v. Merrell Dow

Many criticized the *Frye* test for only applying to novel or brand-new scientific testimony, which meant the courts had trouble defining the appropriate scientific community to decide if a given scientific principle was generally accepted. It also was criticized as too conservative because it excluded reliable evidence that had the misfortune of being novel. Ultimately, the concerns over scientific expert testimony began to focus on the admission of junk science. **Junk science** was considered to be expert testimony on issues that were not well established in the scientific community but were useful to the legal system in some manner. For example, the testimony of representatives

of the tobacco companies suggesting that cigarette smoking does not cause cancer has been used as an example of junk science outside of psychology (Givelber & Strickler, 2006). In *Daubert*, the Court concluded that the *Frye* test was obsolete and that the admissibility of scientific expert testimony would now be governed by the requirements of *Daubert* (*Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 1993). See Figure 3.1 for an example of *Daubert* in action.

Daubert originally involved a claim by two plaintiffs on behalf of their children born with severe birth defects. The trial court excluded the testimony of the plaintiff's experts attempting to prove the link between use of the drug Bendectin and the children's birth defects. The Supreme Court ultimately reversed the lower court decision to

Alex Wong/Getty Images

Figure 3.1. In 2005, Lewis "Scooter" Libby Jr. was indicted on numerous charges related to the disclosure of covert CIA agent Valerie Plame. Libby hired several renowned psychologists to present psychological research to jurors but the court deemed the testimony inadmissible under *Daubert* because it believed the underlying studies were of questionable validity, the testimony would not assist the jury, the prejudicial effect of the testimony outweighed its probative value, and the testimony would replace the jury as the trier of fact.

exclude the plaintiff's expert evidence and held that the *Frye* general acceptance test was not the proper rule for deciding the admissibility of scientific evidence (*Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 1993). The Court identified the role of the trial judge as that of a gatekeeper in regard to all scientific testimony and specified a two-part admissibility screening process that focused upon *relevancy* and *reliability*. The Court indicated that in order for scientific evidence to be relevant, it must relate to the issues at hand. Taking its direction from the relevancy test, the Court indicated that the trial judge had the discretion to exclude relevant testimony when the probative value was outweighed by the prejudicial impact of the testimony.

In devising its second criterion, reliability, the Court relied on Federal Rules of Evidence (FRE) 702. However, the Court understood the term *reliability* to mean scientific validity. The Court was incorrect when it suggested that judges were interested in the consistency of expert evidence (reliability) when they were really interested in the accuracy of expert testimony (validity). Nonetheless, to establish reliability the Court identified a list of guidelines:

1. Is the theory or technique at issue testable and has it been tested?
2. Has the theory or technique been subjected to peer review or publication?
3. What is the known or potential error rate for scientific techniques?
4. Is the theory generally accepted in the scientific community?

It is apparent from this list that *Daubert* also incorporated, as one component of the new test, much of the previously used *Frye* test, which called for general acceptance.

Daubert was certainly a landmark decision as indicated by the volume of commentary that followed (e.g., Black & Singer, 1993; Imwinkelried, 1993). Despite the volume of debate, there was little agreement how this standard would affect the admissibility of scientific evidence (Faigman et al., 1994; Fenner, 1996). Though the Court believed the new standard would be more in keeping with the expanded thrust of the Federal Rules of Evidence and that courts would be able to exercise more flexibility (*Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 1993), the actual consequences were originally unclear. It also was unclear how judges, without any scientific training, would evaluate the scientific merit of scientific testimony.

The Rest of the *Daubert* Trilogy

Two additional cases attempted to clarify the scope of *Daubert*, the procedures concerning the admissibility of expert testimony, and completed the trilogy of cases that form the foundation for the admissibility of modern expert testimony in the United States. The issue before the Supreme Court in *General Electric Company v. Joiner* (1997) was the standard of review for reversal of lower court decisions concerning the admissibility of scientific evidence. In essence, the case identified the extent to which a trial court judge must err in his admissibility decisions for an appeals court to overturn it. The Court ruled that a single standard, abuse of discretion, was appropriate. It was not the particular legal standard that was important, but that this legal standard was high.

The abuse of discretion standard suggests that a trial court judge needs to make a clearly unreasonable decision in admitting an expert's testimony, and therefore the Court was deferring to trial court judges as the ones ultimately responsible for applying *Daubert*. The term *gatekeeper* has been used to signify this role of the judge as the one who is the ultimate arbitrator of the scientific merit for an expert's testimony.

In *Kumho Tire Co. v. Carmichael* (1999) the issue was whether nonscientific or technical testimony should be evaluated by *Daubert* criteria. Were the courts holding scientific experts to a higher standard than technical experts? The Court ruled that *Daubert* extended to technical knowledge and that it should be applied with some flexibility by the trial court judge. This ruling clearly applied *Daubert* to aspects of clinical psychology whose scientific validity were debated by the courts. By extending *Daubert* to technical and specialized knowledge, the courts did not have to come up with a different standard for clinical psychology compared to aspects of psychology that were less applied and more empirically established.

So, while the Supreme Court continued to clarify its original decision in *Daubert* through *Joiner* and *Kumho*, the true impact on the expert witness was not completely clear. Did these additional standards actually make it harder for scientific evidence to be admitted? Did *Daubert* keep out junk science? Groscup, Penrod, Studebaker, Huss, and O'Neil (2002) examined almost 700 appellate court cases that occurred prior and subsequent to *Daubert* and found a number of interesting results that might suggest the true impact of *Daubert*. Overall, there was not a noticeable impact on the admissibility of expert testimony. Their research found that the courts spent more time examining experts' qualifications rather than their methods and that assisting the trier of fact was the most important criterion for admission compared to any of the four *Daubert* criteria. These results suggest that instead of scrutinizing the quality of the scientific testimony, the courts continue to rely on the same standards as they did prior to *Daubert*. *Daubert* may have increased the scrutiny regarding the practice of forensic psychology, but it probably did not actually increase the threshold for the scientific merit of it. Because judges are not trained to be scientific experts, they may instead rely on the usefulness of the expert's testimony or whether it will assist the court. Despite these findings, *Daubert*, *Joiner*, and *Kumho* suggest that forensic psychologists should expect greater legal scrutiny and as a result there should be an improvement in the scientific basis of psychological testimony admitted into courts (Faigman & Monahan, 2005). The Supreme Court cases relevant to admissibility of scientific testimony are summarized in Table 3.1.

Challenges to Expert Testimony

Cross-examination

In addition to excluding an expert's ability to testify as a matter of law, there are several other ways in which the testimony of an expert can be challenged in court. The most common method of challenging an expert is cross-examination. In fact, the courts even rely on the use of cross-examination as a way to challenge expert testimony they believe

Table 3.1. Supreme Court Cases Relevant to Admissibility of Scientific Testimony

Supreme Court Case	Summary of Decisions
Frye v. United States (1923)	Scientific testimony admitted if generally accepted in the scientific community
Daubert v. Merrell Dow Pharmaceuticals, Inc. (1993)	Scientific testimony admitted if relevant and reliable according to four potential criteria
General Electric Co. v. Joiner (1997)	Trial judge is the clear gatekeeper for admission of scientific evidence
Kumho Tire Co., Ltd. v. Carmichael (1999)	Prior rulings on the admissibility of scientific testimony apply to technical and specialized knowledge

may be suspect, even though it is admitted. The law believes not only that judges who have not been trained in a scientific field can evaluate its scientific merit, but that a jury can do the same because of the power of cross-examination. Cross-examination occurs after a witness has testified and the opposing attorney is able to question the expert directly. Brodsky et al. (2002) summarized the cross-examination of an expert witness by stating, "More than any other aspect of the legal process, witnesses fear the cross-examination. We have come to think of the cross-examination as a battle for power and control between the witness and the attorney" (p. 30). Discrediting or impeaching an expert witness normally occurs through the use of prior inconsistencies that were recorded in past cases or published in professional materials. An expert may have stated one opinion in prior testimony or even published a book with the stated opinion and then contradicted those statements in current testimony. A well-prepared attorney will research prior statements looking for these instances in order to discredit an expert (Ewing, 2003). Opposing attorneys also rely on other scholarly material that may contradict the expert's opinion by pointing out that other experts in the field disagree with an expert, if those materials or methods have been relied upon by the present expert. Empirical evidence indicates the tactic can be successful, as effective cross-examination of an expert witness has altered verdict choices in mock juror studies (e.g., Spanos, Dubreuil, & Gwynn, 1991).

Opposing Expert

Another way in which an expert can be challenged is through the use of an opposing expert. Though this method results in much less of an emotional toll on the expert, the result can be similar. However, opposing experts can increase the cost of a trial, leave the judge and jury confused, and lead to the frequent criticism of dueling experts, thereby taking the focus off the real issues and putting more emphasis on expert testimony (Hess, 2006b). Nonetheless, our previous discussion of the Nietzel et al. (1999) meta-analysis suggests that expert witnesses can have a modest impact. Furthermore, Devenport and Cutler (2004) found that opposing testimony by the prosecution could

decrease the impact of the defense's expert witness. Therefore, there appears to be some empirical support for this approach as well.

Judicial Instructions

A final challenge to expert testimony is the use of judicial instructions. A judge typically reads a list of instructions to a jury prior to discussion of the case, which the jury is supposed to follow during the deliberation process. Judges can instruct jurors as to the scrutiny to give certain testimony or even frame the testimony in a particular manner for the jury. The empirical research is clear that jurors have a great deal of difficulty understanding and applying judicial instructions (Ogloff & Rose, 2005; Penrod & Cutler, 1987). However, there are a host of variables such as timing, purpose of the instructions, and nature of the instructions that play a role in juror comprehension and impact on the final verdict (Ogloff & Rose, 2005; Penrod & Cutler, 1987). At least one study has even found that expert testimony is more likely to have an impact on the jurors than a judge's instructions (Cutler, Dexter, & Penrod, 1990). However, the legal system continues to view judicial instructions as a way to influence jurors regarding their evaluation of expert testimony.

Factors That Influence Expert Witness Credibility

In addition to the legal realities that impact the job of the forensic expert witness, there are also several factors that have been identified as influencing the credibility or believability of expert witnesses. There are a number of factors that commentators have suggested increase the credibility of an expert witness. These factors include dressing professionally, familiarity with the courtroom, maintaining good eye contact, projecting your voice, and demonstrating composure in the adversarial context (Brodsky et al., 2002; Melton, Petrila, Poythress, & Slobogin, 2007). Azevedo (1996) and Blau (1998) have independently argued that there are factors that reduce the credibility of an expert such as spending an excessive amount of time testifying relative to one's primary profession, testifying on issues outside the expert's area of expertise, a lack of knowledge about the current case, inconsistencies across different cases in which an expert has testified, and using improper scientific methods.

However, the factors suggested by these authors are largely theoretical. There is a body of empirical findings that also has identified factors that influence the credibility of an expert witness. For example, mock juror studies have focused on the hired gun effect. The **hired gun** effect has been described as making experts appear less credible because the experts have been paid by a given side to testify. Cooper and Neuhaus (2000) examined the level of pay (high or low), level of credentials (high or modest), and the frequency of testifying (frequent or novice) across three mock juror studies. They consistently found that highly paid experts who testified frequently were less believable and less well liked by potential jurors. Boccaccini and Brodsky (2002) took it one step further and conducted a phone survey of 488 community residents. Results

revealed that respondents were more likely to believe experts from their local community compared to national experts, experts who actively practiced, experts who testified for the prosecution and the defense in previous trials, and experts who were paid nothing. Although it might be difficult for a forensic expert to follow all of these findings and still make a living, they should be considered by attorneys and experts concerned about looking like a hired gun.

Kwartner and Boccaccini (2008) identified the four Cs of effective expert testimony based on their review of 62 experimental studies on expert witness: clarity, clinical knowledge, case-specificity, and certainty. *Clarity* suggests that the expert should be clear and understandable in order to assist the court. Clarity is characterized by communicating technical information in a nontechnical manner and using jargon-free testimony. A supervisor once told me that people use a lot of jargon either because they don't know what they are talking about or they don't want others to know what they are talking about. To some extent, the courts can probably pick up on this notion and tend to discount information that is presented in an overly inflated manner. Kwartner and Boccaccini also argue that *clinical knowledge* is more persuasive when it is based on the expert's experience and knowledge, not simply on statistically or actuarial based information. The third principle of *case-specificity* suggests that expert's opinions geared toward the case at hand are more persuasive. Typically psychologists rely on generalized findings from empirical studies. An educational function would be for the expert to describe these general findings to the court, whereas an evaluative approach would be for the expert to explain the relevance of those findings to a specific situation and base their conclusion on those studies in regards to that specific case. Kwartner and Boccaccini argue that a more evaluative approach is more persuasive. *Certainty* is the final principle and the literature generally suggests that a high level of confidence without being overly confident is the best approach.

Criticisms of Expert Testimony

A number of criticisms have arisen from both psychology and the law regarding forensic psychologists testifying as expert witnesses. Some of these criticisms may be the result of the inherent conflict between the two disciplines and the general adversarial nature of the legal system, whereas others may occur for other reasons.

Taking Over the Courtroom

Several scholars have suggested that psychologists are increasingly being asked to assist the courts (Dvoskin & Guy, 2008; Knapp & VandeCreek, 2001; Saunders, 2001). However, concern also has been voiced that psychologists are not only testifying but "taking over the courtroom" (Coles & Veiel, 2001, p. 607). The concern with the increased use of experts is that it may mean experts are not only informing the judge or jury of information beyond their knowledge but replacing their decision-making ability. This concern is especially heightened when psychological testimony is offered that fails to

meet the standards for scientific testimony. Coles and Veiel (2001) articulated significant concern that mental health testimony is being misused because of a lack of scientific rigor and have encouraged the courts to limit the testimony of forensic psychologists. This criticism becomes of even greater importance in the case of ultimate issue testimony.

Ultimate issue testimony

Ultimate opinion or **ultimate issue testimony** is expert testimony in which the expert not only gives a conclusion but answers the ultimate legal question that is presently before the court. For example, the ultimate legal question in a criminal trial is whether the defendant is guilty or not guilty. If a forensic psychologist was called to the stand in a criminal case or wrote a report stating that, based on his evaluation of the defendant, the defendant was guilty, that would constitute ultimate opinion testimony. Of course, it sounds a little silly that a psychologist would testify directly that a person was guilty or not guilty, because that is the role of the judge or jury. Traditionally, ultimate issue testimony that occurs in situations involving insanity, competency, and risk of future dangerousness has been viewed as inappropriate because it addresses a legal question, not a psychological question, and it is beyond the role of an expert in mental health (Ewing, 2003; Wilkinson, 1997).

Psychologists are not routinely trained in the law or to be lawyers. Psychologists are trained in psychology and therefore are competent in psychology. To testify or work outside of psychology or one's expertise in psychology would be to work outside of one's *scope of practice* or role as an expert. Melton et al. (2007) argue that psychologists should avoid testifying or writing to the ultimate issue for this reason. Not only are psychologists such as Melton and colleagues worried about practicing outside one's area of competence, but the legal system may be concerned that psychological findings will have too great an impact on the final decision of the fact finder (Fulero & Finkel, 1991). As a result, psychologists were specifically barred from testifying to the ultimate issues in federal insanity cases after the passage of the Insanity Defense Reform Act in 1984 and as further indicated in FRE 704b (Finkel, 1990; Wilkinson, 1997).

There are several problems with avoiding ultimate issues testimony. Judges and attorneys often expect, if not demand, that psychologists give an ultimate conclusion when they testify (Gutheil & Sutherland, 1999; Melton et al., 2007). A survey of judges and attorneys confirmed this impression (Redding, Floyd, & Hawk, 2001). Redding et al. (2001) asked trial court judges, prosecutors, and defense attorneys to respond to a questionnaire asking eight questions regarding the testimony of an expert in an insanity case. Results confirmed that participants preferred ultimate opinion testimony even though FRE and state law specifically barred ultimate opinion testimony in these cases. Other psychologists argue that prohibiting ultimate opinion testimony is misguided (Rogers & Ewing, 2003; Sales & Shuman, 2005). Furthermore, there are instances when forensic psychologists are legally compelled to give an ultimate opinion, such as when a person is evaluated for competency to execute a will. In further support of the use of ultimate opinion, several studies have examined the

impact of ultimate opinion testimony (Fulero & Finkel, 1991; Rogers, Bagby, Couch, & Cutler, 1990). Rogers et al. (1990) presented 274 adults abbreviated trial transcripts and found no significant differences in the verdict choice of those subjects who received ultimate opinion expert testimony and those who did not receive ultimate opinion expert testimony. Clearly psychology is still divided on the appropriateness of ultimate issue testimony.

Corruption of Science

Another criticism of forensic experts that applies to expert testimony is that the nature of the adversarial process corrupts the objective nature of science and therefore introduces bias into scientific testimony (Shuman & Greenberg, 2003). In fact, Margaret Hagen has gone so far as to write a book about it entitled, *Whores of the Court* (Hagen, 1997). As we have noted before, the legal system and psychology have different philosophical approaches to addressing a potential question. One approach is not necessarily superior to the other, but they are different, and these differences can cause difficulties when legal actors are not educated as to the differences and psychologists fail to maintain their scientific integrity (Sales & Shuman, 1993). Psychologists need to be aware that attorneys may do things as part of their legal strategy that appear foreign to psychologists. For example, some attorneys retain an expert simply so the other side cannot call that expert as a witness. As a result, forensic experts need to be aware of the different values of each system and the potential for a resulting loss of their scientific objectivity. Gutheil and Simon (2004) specifically identified several sources of this potential bias in forensic work.

Financial incentives

Maybe the biggest source of a potential bias that leads to the appearance of a corrupt scientific process is the financial reward of serving as an expert. One survey of the case law looking for mentions of *whores* and *prostitutes* directed toward mental health professionals, inspired by the Hagen book, even concluded that "the perception among legal professionals [is] that many mental health experts are unscrupulous" (Mossman, 1999, p. 414). Some experts earn over $10,000 for their work on a single case and there is increasing sensitivity to the appearance and problems associated with being a so-called hired gun (Boccaccini & Brodsky, 2002; Cooper & Neuhaus, 2000). Edens and colleagues (2012) even examined 160 different published criminal civil cases and found that charges of being "for sale" were the most frequent bias leveled against forensic psychologists (Edens et al., 2012). Some even suggest there is no such thing as an objective expert anymore and prominent forensic experts have refused to testify in court because of the potential biasing effect (Colbach, 1997). Nonetheless, a survey of attorneys found that the majority did not choose forensic psychologists because of their willingness to give a dishonest opinion but on their knowledge, communication skills, and reputations (Mossman & Kapp, 1998). Forensic psychologists must be very mindful of the perceived bias and make it clear that they are being paid for their time as an expert and not for their testimony.

Extra-forensic relationship

Another issue mentioned by a number of commentators is the occurrence of extra-forensic relationships. These relationships can exist in a number of ways. The most readily identifiable relationships occur when one of the parties involved in a court case is a friend or family member of an expert. However, the extra-forensic relationship also can occur when the involved party and the forensic psychologist are members of the same professional organization or institution (Gutheil & Simon, 2004). For example, the forensic psychologist and one of the involved parties could belong to the same civic organization or church. The criticism is that the relationship can cloud the objectivity of the expert and be used to suggest that a given expert's work product or testimony is biased. I routinely ask attorneys to identify their client in order to assess any extra-forensic relationships I may have or potential conflicts of interests from other clinical work.

Attorney pressure

It is very likely that an expert will feel pressure from attorneys. Attorneys are bound by their own professional ethics to fight for their clients to the best of their ability and they need not be objective in their work. However, the forensic expert is supposed to be honest and objective (Gutheil & Simon, 1999). As a result, it is quite natural for conflict to occur in these situations and for the expert to experience pressure to perform in a certain manner or offer a particular type of testimony. These pressures may come in the form of the attorney expressing an assumed opinion, offering only selective data for the expert's review, claiming to have another expert who will perform the task without any problem, claiming financial hardship, or exhibiting an unfavorable response to an initial opinion (Gutheil & Simon, 1999). The expert must be able to identify these instances and resist the pressure to perform in a particular way. In one instance an attorney asked me to delete a reference from my report about a particular psychological test because it was not consistent with the rest of my findings and it was unfavorable for the case. I refused to do so. The attorney ultimately understood my rationale and it was never mentioned by the opposing side.

Political and moral beliefs

Another source of potential bias can come from political or moral beliefs (Gutheil & Simon, 2004). Moral biases can arise in cases involving issues like abortion or child custody. Political issues that clash with either side of the conservative and liberal spectrum of political beliefs, such as death penalty cases, are also problematic for the forensic expert. For example, an expert may choose to only testify for either the prosecution or the defense in these cases because of her beliefs for or against the death penalty. In these instances, the expert's final opinion may be dictated before the evaluation ever takes place and objectivity is completely destroyed. Experts should consider the bias their personal, moral, and political beliefs may introduce and refuse cases in which this bias cannot be properly managed.

Notoriety

Potential bias arises from the limelight or notoriety that may accompany serving as an expert witness (Gutheil & Simon, 2004). Being a part of the media barrage of a given case and receiving public acclaim can be very attractive. A colleague of mine and I have routinely discussed the lure of this type of attention and he has admitted to enjoying aspects of the process. As a result, I have grown fond of referring to him by the name Icarus, from the Greek myth in which Icarus flew too close to the Sun because he lost himself in the thrill of flying. Icarus had a pair of wings made of feathers and wax, which melted as he flew too close to the Sun and he soon crashed to the Earth. In these situations, the forensic psychologist runs the risk of getting too close to the Sun, or the fame of testifying in high-profile cases, and may get burned by the loss of objectivity. Although the consequence is not as severe for the forensic psychologist as it was for Icarus, it can still be a source of bias.

Competition

A final source of potential bias is competition (Gutheil & Simon, 2004). Bias from competition may occur for several reasons that relate to the legal context, professionalism, or the expert's personality. For example, an expert might be more prone to take a case, especially a high-profile case, which may test her objectivity because another colleague will assist the attorney if she refuses it. An expert also may want to perform better than an opposing expert and seek to offer a conclusion not because it is the correct one but because it will trump an opposing expert's opinion. The legal process itself also can encourage tendencies to win that many people, especially successful ones, naturally may have developed over their lifetime. These tendencies may become even greater as an expert becomes more successful testifying, gets more comfortable, and is sought after more frequently by attorneys.

Lack of recognition of bias

However, the real danger in any of these potential sources of bias is not that the bias exists but that the bias goes unrecognized and affects the process, the writing of the report, the conclusion, or even the testimony of the expert (Gutheil & Simon, 2004). At least one study examined potential biases among experts (Commons, Miller, & Gutheil, 2004). Commons et al. (2004) solicited questionnaire responses from 46 attendees at a professional workshop and concluded that experts "wildly underestimate the biasing effects of their own conflicts of interest and other factors" (p. 73). For example, participants did not believe that the amount of money involved in a case, the high-profile nature of a case, the expert's personal philosophy or social agenda, or relationship to the attorney hiring them created bias. These results suggest that forensic experts should be especially on guard for sources of potential bias and not minimize the degree to which they may impact their professional judgment. The lack of recognition makes outside consultation even more important, as will soon be discussed. Table 3.2 summarizes the criticisms of expert testimony and sources of scientific corruption.

Table 3.2. Criticisms of Expert Testimony and Sources of Scientific Corruption

1. Taking over the courtroom
2. Testify to the ultimate issue
3. Use of experts corrupts science for several reasons:
   - Financial incentives
   - Extra forensic relationships
   - Attorney pressure
   - Political and moral beliefs
   - Notoriety
   - Competition
   - Lack of a recognition of sources of bias

Ethics of the Expert

An important aspect of performing as a forensic psychologist and especially as an expert witness is adhering to a set of professional guidelines or ethical principles. It is especially important for psychologists in their roles as forensic experts to perform in an ethical manner for many reasons, which we have already touched on in this book. Factors such as the adversarial nature of the legal system, the significant consequences of legal decisions, and the public nature of forensic work all converge to make ethical practice as an expert witness especially important. The legal system sometimes conflicts with the practice of psychology and even the ethical principles of psychologist as objective practitioners of science. The ethical ideal of the adversarial legal system is to fight for a client to the best of your ability. In essence, you are not supposed to be objective, you are supposed to be an advocate. As a result, it is even more important that a forensic psychologist maintains a firm ethical foundation in the face of pressure from the legal system. Forensic psychologists assist the legal system with decisions that have far-reaching implications. It is important not only to be correct when testifying on the potential for violence for someone facing the death penalty but to do so in an ethical manner. Also, as discussed in Chapter 1, the public often forms their view of psychology from the media (Stanovich, 2004). The more sensational media images are very likely to come from forensic psychology (Huss & Skovran, 2008). As a result, forensic psychologists have a special duty to behave in an ethical manner because the public forms much of its view of psychology from these media images.

Many professions have a set of ethical principles or ethical guidelines that individuals in that profession follow and psychology is no different. In fact, there are several potential sources of professional and ethical guidelines for forensic psychologists. The primary source of ethical principles for psychologists is the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (APA, 2002). But why have these ethical codes? Hess (1999) suggests that because society grants a particular profession a monopoly, the profession must take it upon itself to serve the public's best interests and not simply serve the profession. Ethical codes serve these interests. Frankel (1989) identifies several functions for ethical codes that largely focus on the need to educate

the public, instill trust in a profession, identify a shared set of values and skills for members of a profession that can serve as a professional compass, and provide a mechanism for sanctions against unethical professionals as well as a mechanism for protecting professionals from unwarranted claims by clients.

Competence

The most obvious area of ethical concern in forensic expert testimony is the need to be competent (Sales & Shuman, 1993). The APA Code (APA, 2002) explicitly states that psychologists should only practice "with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study or professional experience" (p. 1063). In other words, psychologists must stay within their **scope of practice**. Their competency comes from having sufficient education and experience in a given area to make reliable and valid professional conclusions. For example, a forensic psychologist is competent to practice forensic psychology but is not competent to practice law unless he or she actually has a law degree and has obtained additional professional experience to practice law. That is not to say that a forensic psychologist does not need to be familiar with the law governing the practice of forensic psychology (Shapiro, 2002), but that the expert must simply avoid practicing as a lawyer instead of a psychologist.

Furthermore, someone might be trained as a forensic psychologist but that does not give her the requisite experience to practice all aspects of forensic psychology. Someone who is only trained to diagnose adult psychopathology would not be competent to perform child custody evaluations. She needs to be familiar with mental illness but also with developmental psychology and the literature on parenting to adequately assess someone in a child custody situation. A psychologist may even be competent to practice in a given area but not competent to use a particular psychological test (Rotgers & Barrett, 1996). A forensic psychologist may attempt to assess someone for depression in a personal injury case but not be competent to use the MCMI-III because he was never trained to do so in graduate school, was never supervised in practice, and never attended any professional workshops on this psychological test (Knapp & VandeCreek, 2001). Furthermore, psychologists have an ethical obligation not only to be competent but to maintain their competence and expertise by participating in opportunities for continuing education. They need to keep up on developments for any method or test they seek to use (Shapiro, 2002). Scope of practice is not only relevant to individuals practicing within forensic psychology or particular areas of forensic psychology. It is also relevant to the profession as a whole. For example, in Chapter 12 we will discuss not only the relevant legal considerations and psychological techniques involved in child custody decisions but also whether those techniques meet a threshold requirement and are sufficient enough to actually inform the courts. Have we demonstrated adequate reliability and validity to perform child custody evaluations? If not, psychology as whole is practicing outside of its scope of practice. This notion may seem rather simplistic at this point, but we will continually discuss instances in which it could be questioned whether forensic psychologists are practicing within their scope of practice.

Of course, a forensic psychologist cannot be expected to have a complete grasp of every topic that comes up in a given case or with a particular person. Competence does not mean knowing everything. As a result, it is a very good idea for forensic psychologists to seek out consultation with other experts when they are unsure about ethical or factual issues that confront them in order to be competent (Dvoskin & Guy, 2008). Consultation may consist of making a phone call to a respected colleague to talk over a particular issue or even paying another expert in a particular area for his or her time to discuss a case or review your report. I routinely consult with a colleague from graduate school when I question findings in an assessment and he in return consults with me. I believe the process makes us both more competent.

Informed Consent and Confidentiality

Two other related ethical issues are the requirement for obtaining informed consent and confidentiality. It is routine in the practice of clinical psychology that we obtain the consent of a client to undergo an evaluation or participate in treatment (Stanley & Galietta, 2006). Informed consent consists of describing the procedures and the process as it is likely to happen and obtaining the client's legal consent to proceed. Obtaining informed consent is also necessary in a forensic context and the APA code of ethics even makes special mention of obtaining informed consent when services are court-ordered in 3.10c of the Ethics Code (APA, 2002). In a forensic context, a person may be experiencing additional coercion either because of his or her own secondary gain or because a legal authority is mandating the evaluation.

Related to obtaining informed consent is the idea of confidentiality. As most people assume, there is both statutory and case law upholding the confidentiality of the therapist–client relationship (Glosoff, Herlihy, & Spence, 2000). Although this privilege does have some limitations depending on the jurisdiction (e.g., reporting child abuse), clients may assume that this privilege exists universally. A problem arises if patients assume this same privilege exists in a forensic assessment where confidentiality is then further reduced (Knapp & VandeCreek, 2001). If the court mandates a report or an attorney requests an evaluation of a defendant in a criminal case, the report could be read by the judge and the opposing attorneys, and potentially introduced into evidence in open court where the forensic psychologists will testify about it. This practice does not allow for the same level of confidentiality one normally experiences when seeking therapy.

A problem arises if a forensic psychologist does not explain this limitation to an individual or the individual does not understand this limitation (Hess, 1999). It is important that an examinee recognizes the limits of confidentiality in a given case and that he clearly understands prior to beginning the process. It becomes further complicated because explaining these limitations conflicts with the forensic psychologist obtaining information in an open and honest manner. If a client misunderstands and believes that everything she discusses is confidential, she will be more likely to reveal information that is harmful to her legally, but may be useful for the evaluation. There is a conflict for the forensic psychologist. On one hand he has an ethical obligation to obtain truly informed consent, but on the other hand the assessment will be more

accurate if the information he obtains from the parties involved is believed to be confidential. Nonetheless, the ethical responsibility for informed consent is more important. In one instance I was explaining the limits of confidentiality to an examinee. The examinee said he understood but that his admissions did not matter because his attorney had told him unfavorable information would be removed from the report if the attorney wished. I was not sure whether the attorney actually told the client that, but I made it even more clear that this was not the case and that anything he said to me could have significant implications for his case and the potential outcome.

Financial Arrangements

Another potential ethical issue that experts confront are the financial issues related to being a forensic expert. These issues are increasingly important as forensic psychology is seen as a financially rewarding area of practice. This area seems a rather mundane one for a potential ethical conflict to occur but it is actually of great concern. The APA Ethical Code (APA, 2002) encourages establishment of financial arrangements as early as possible in the relationship and an expert may even require payment in advance and be very specific about the services being charged for and the specific fees (Knapp & VandeCreek, 2001).

Perhaps the most salient reason for handling financial matters in this manner is the potential impact of any compensation on the forensic conclusion. Psychologists should not perform forensic services on a **contingency fee** basis where the psychologist is paid for his or her services based on the conclusion (Knapp & VandeCreek, 2006). Such a practice has serious complications for the objectivity of the forensic process. Obvious examples of a contingency fee arrangement are normally easily identifiable but more subtle situations such as an attorney refusing to pay unless a report is "slightly" altered are potentially more dangerous.

Multiple Relationships

The APA Ethics Code (APA, 2002) states that psychologists should avoid multiple relationships "if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists" (p. 1065). Typically, the focus of multiple relationships as an expert focuses on the conflict between being a treating therapist and a forensic evaluator (Shuman, Greenberg, Heilbrun, & Foote, 1998). There may be situations in which these relationships cannot reasonably be avoided, such as if a psychologist is the only mental health professional in a rural area or a psychologist requires information on a patient who has been court-ordered into treatment (Knapp & VandeCreek, 2006). The forensic psychologist needs to be aware of the potential harm that can result in these situations.

There are a number of potential ethical problems that can arise from circumstances in which a multiple relationship exists: For example, being asked to evaluate someone in a child custody dispute to whom you have previously delivered psychotherapy (Shapiro, 2002). The difficulty arises because the focus in a forensic context is no longer the

welfare of your client but your obligation to the attorney or court that has hired the forensic psychologist. The focus is on giving them objective information (Knapp & VandeCreek, 2006). Suppose a psychologist is treating a woman who is suffering from anxiety and then is asked to perform a custody evaluation to help the court decide the custody of her two children. The psychologist is placed in a potentially compromising situation no matter the conclusion. If the opinion is unfavorable, the finding is very likely to impact the therapeutic relationship in the future and decrease the chances of a successful process because the therapeutic relationship has been damaged. If the conclusion is neutral, the psychologist might be pressured to provide a more favorable conclusion by a client. If the conclusion is positive, there will be an appearance of favoritism. Moreover, a psychologist can never be sure whether his report simply verified his previous therapeutic assumptions or is really objective and truly answers the court's question. As Shapiro (2002) notes, "one cannot be an effective therapist in terms of assisting a client or patient to deal with her or his difficulties if one has been involved in doing a comprehensive forensic evaluation of that individual" (p. 46).

Syndrome Evidence: Controversial Area of Expert Testimony

In concluding the chapter on expert testimony, we will focus on an area of forensic expert testimony that is often controversial. In examining **syndrome evidence** and the controversy that surrounds it, the goal is not to indict forensic psychologists who testify as experts in these cases. In fact, we could choose a variety of other issues such as using psychopathy in death penalty cases or performing risk assessments in Sexually Violent Predator commitment hearings. However, an examination of expert testimony involving syndrome evidence offers a unique opportunity to look at a specific area in which a great deal of controversy exists both from a legal perspective and from a psychological perspective. Syndrome evidence also serves as an example in which psychological information that is useful in one context is questioned if used in another context. In addition, it helps give a real-life context for issues we will be discussing throughout this book, such as staying within one's scope of practice and the impact the law can have on forensic practice and the lives of others.

Profile and Syndrome Evidence

The use of profile or syndrome evidence has been controversial for decades, almost since their introduction in psychology and the legal system (Dahir, Richardson, Ginsburg, Gatowski, & Dobbin, 2005; Frazier & Borgida, 1985; Schuller, Wells, Rzepa, & Klippenstine, 2004). For example, Battered Woman Syndrome was first introduced in a United States court in the 1970s (*Ibn-Tamas v. United States*, 1979) and later in the Canadian courts (*Regina v. Lavelle*, 1988) in defense of women who killed their abusers. Soon a variety of other syndromes were identified in the psychological literature and made their way into the courts (e.g., Frazier & Borgida, 1985). The terms *profile* and *syndrome*

have been used interchangeably (Dahir et al., 2005) and will only be differentiated at a superficial level in this discussion. The term *syndrome* refers to a set of symptoms that occur together in a meaningful manner and typically have a triggering event. Profiles are similar but tend to be more specific and are used to predict behavior because someone matches a particular list of characteristics drawn from the syndrome. For example, many of you have heard of racial profiling, in which an individual is identified as someone of interest or arrested largely because of his or her race or ethnicity. If the federal government were to search only those people at the airport who appeared to be of Arab or Muslim descent, it would be using racial profiling. Although racial profiling is one form of profiling, our examination will focus on psychological profiles based on syndromes. The reason we will use these terms interchangeably is that in discussing syndrome evidence, the controversy arises not only from the discussion of the syndrome itself but from experts testifying about syndromes in ways that make them seem more like profiles.

There are literally dozens of different syndromes that have been noted in the psychological literature and offered into evidence in the courts (Brodin, 2005). A typical list of syndromes includes battered woman syndrome, rape trauma syndrome, battered child syndrome, child sexual abuse syndrome, child sexual abuse accommodation syndrome, and Munchausen syndrome by proxy among others. See Box 3.2 for a complete description of battered woman syndrome as an example of syndrome evidence. Syndrome evidence was initially used in courts to explain seemingly unusual behavior by someone who was a victim of a specific trauma in order to educate the jury as to the reasonableness of unusual behavior (Moriarity, 2001). Battered woman syndrome would be used to explain the reason for a woman failing to leave an abusive relationship or believing that abuse was imminent despite the batterer being passed out asleep (Huss, Tomkins, Garbin, Schopp, & Kilian, 2006). Rape trauma syndrome would be used as an explanation for a sexual assault victim continuing to interact with her perpetrator in social settings after the assault. Child sexual abuse syndrome would be used to explain the reason for a child failing to report sexual abuse by her stepfather. Syndrome evidence tended to be very helpful for the courts and had both a social and an intuitive appeal when presented by an expert.

However, there were some aspects of this testimony that were unusual. Typically the syndromes were based on the clinical experience of the originators and were not based on extensive research (e.g., see Burgess & Holstrom, 1974, regarding rape trauma syndrome). Furthermore, the research largely failed to validate these syndromes after they were identified by clinicians. For example, the cycle of violence initially explained by Lenore Walker may serve as a useful heuristic to explain the abuse experience for many women but the research has failed to support its accuracy for decades (see Faigman & Wright, 1997, for a review). Syndromes also are problematic because there are likely to be a significant number of false positives, meaning there are a high number of people who may be identified as exhibiting the syndrome when they actually do not suffer from it. This is can be true even if they experience the sexual assault or physical abuse that can trigger the syndrome (Richardson, Ginsburg, Gatowski, & Dobbin, 1995).

However, syndrome evidence is not only being used to explain unusual behavior of a criminal complainant in a sexual assault case or a battered woman who kills her abuser

Box 3.2. Focus on Research: Battered Woman Syndrome

Battered woman syndrome (BWS), as originally conceptualized by Lenore Walker (1979; 1984), consists of a list of characteristics that are subsumed in two primary components, a cycle of violence and application of learned helplessness to women who have been the victims of an abusive partner. Walker stated that women who experienced prolonged abusive relationships often experienced three different phases of violence that included the tension-building phase, the explosion or acute battering incident, and the honeymoon phase that consisted of calm, loving respite in which the batterer was apologetic for his abuse (Walker, 1979). As a result of this abuse, the woman typically experienced learned helplessness and did not think there was anything she could do to stop the abuse.

The idea of learned helplessness was borrowed from the efforts of Martin Seligman's pioneering work on dogs. Seligman stumbled on the idea of learned helplessness in his research focused on depression. Seligman discovered that dogs who were unable to escape from an apparatus during the delivering of electrical shocks learned to simply lie in the cage when they were later able to avoid the shocks. Walker believed there was a similar principle at work among women who had been the victims of ongoing abusive relationships, which resulted in battered woman syndrome. She described four general characteristics of the syndrome that included: (1) the woman believing the violence was her fault; (2) an inability to place the responsibility for the violence with anyone else; (3) fear for her life and the life of her children; and (4) an irrational belief that the abuser is all-knowing and all powerful (Walker, 1984).

Unfortunately, there is not sufficient empirical evidence to support this conceptualization as accurate (Rothenberg, 2003; Schuller & Vidmar, 1992). In fact, some argue that BWS is simply PTSD for women from abusive relationships and Rothenberg (2003) suggests that its acceptance as a valid concept was largely the result of cultural motivations. Nonetheless, the term continues to be accepted by many psychologists and certainly by many advocates for victims of domestic violence. This very popular construct serves as a cautionary tale for forensic psychologists.

and is charged with a homicide. Syndrome evidence is increasingly used in a substantive manner, directly or indirectly, to support a particular claim with potentially little additional evidence (Moriarity, 2001). **Substantive evidence** is evidence used to prove the fact at issue such as the guilt or innocence of a criminal defendant. For example, a defendant may be charged with sexual assault but admit to consensual sexual intercourse. The burden for the prosecution then becomes not to prove that sexual intercourse occurred but that unwanted sexual intercourse occurred. Prosecutors began to call upon expert witnesses to explain that some of the behaviors the victim exhibited were characteristic of a person who suffered from rape trauma syndrome. Their logic followed that the defendant must be guilty of rape because the victim fits the so-called profile of someone who has been sexually assaulted. In a slightly different approach, an expert might testify that there are a set of characteristics that are routinely found in domestic violence perpetrators and that a given defendant fits the profile of a domestic violence perpetrator. Even Lenore Walker, the most famous advocate for battered women, was supposed to be called as an

expert witness in the O. J. Simpson trial to claim that his ex-wife, Nicole Brown Simpson, did not fit the profile of a battered woman, so Mr. Simpson could not have been abusive toward her (Raeder, 1997). Use of syndrome evidence in this manner constitutes character evidence. As a rule, **character evidence** is not admissible unless the defense opens the door by claiming the defendant is of upstanding character. As a result, expert testimony focusing on syndrome evidence has been admitted with less frequency in a substantive manner to prove or disprove a criminal charge.

Syndrome evidence, whether it is battered woman syndrome, rape trauma syndrome or child sexual abuse syndrome, was controversial prior to its use as a substantive claim in criminal trials because of the general lack of empirical support for any of the syndromes. However, substantive expert testimony is especially controversial because syndrome evidence was not intended to be used as a diagnostic tool to determine if a particular abusive act occurred (Allen & Miller, 1995). A sufferer of Munchausen syndrome by proxy may exhibit the following symptoms: the primary caregiver of a child, most likely a mother, educated, middle to upper class, highly attentive, friendly with medical staff, takes a child to multiple physicians looking for different medical opinions, and appears calm when presented with difficult news, but that certainly does not mean that anyone who exhibits these behaviors suffers from Munchausen syndrome by proxy. This logic of the syndrome testimony suffers from a fundamental flaw when presented in this way. A noted forensic psychologist, John Edens, is fond of this analogy to explain it; most hard drug users may have started out smoking marijuana, but that does not mean that smoking marijuana causes people to then use hard drugs. Almost all hard drugs users started out eating baby food, but do you ever hear anyone argue that eating baby food causes hard drug use? Just because someone is a mother, educated, middle class, and highly attentive to her children does not mean she tries to make her children ill and suffers from Munchausen by proxy.

Legal scholars have claimed that syndrome evidence continues to be successfully admitted despite additional scrutiny because of a host of social, political, and legal reasons (Moriarity, 2001). Additional concerns arise that if syndrome evidence continues to be admitted, it will lead to a decrease in the rigor and scrutiny that courts use in evaluating scientific evidence. In fact, the Arizona Supreme Court has specifically stated in their admission of syndrome evidence that it is in part admitted because the courts are not equipped to evaluate scientific testimony because of a lack of scientific expertise (Faigman, 2001).

There are significant issues in terms of competent practice and staying within one's scope of practice by testifying in these cases, both for the law and psychology. Psychologists should not use the admissibility of this testimony as a de facto indication that the evidence is of sufficient quality to be used in a psychological context and abdicate their responsibility as scientists. As mentioned in the discussion of *Daubert*, judges are not trained to evaluate this information and make fundamental mistakes in examining syndrome evidence as scientifically sound (Dahir et al., 2005). Expert witnesses also address the ultimate opinion in cases in which syndrome evidence is used to prove or disprove the guilt of a defendant and the accompanying concerns by Melton et al. (2007) and others suddenly appear as a result.

The use of syndrome evidence, especially syndrome evidence used to create a profile and address the substantive legal question, is also a potential example of the anti-therapeutic use of psychology in the legal system. Remember that therapeutic jurisprudence is the legal theory that the law can have both therapeutic consequences (positive consequences broadly speaking) and anti-therapeutic consequences (negative). The potential misapplication of psychological theory by experts and the law is clearly anti-therapeutic if it results in individuals who may require psychological intervention failing to obtain the assistance or if it decreases the scientific rigor of expert testimony.

Reflection and Review

1. Why was *Jenkins v. United States* so important to forensic psychology?
2. What biases should forensic psychologists be aware of as an expert? What is the most important source of bias?
3. How are the APA ethical guidelines relevant to forensic psychologists?
4. Why is syndrome evidence an especially problematic issue for forensic psychologists?

Key Terms

character evidence
contingency fee
hired gun
junk science
meta-analysis
prejudicial
probative value
scope of practice
substantive evidence
syndrome evidence
ultimate issue testimony

Further Readings

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4 Psychopathy

Chapter Objectives

1. Define psychopathy
2. Describe the nature of psychopathy in regard to violence, interpersonal/affective behavior, learning and cognition, biology and treatment differences
3. Understand the nature of psychopathy outside of the traditional criminal offenders studied
4. Identify the legal and ethical issues involved in diagnosing psychopathy

What do you think of when you hear the word **psychopathy**? Does a crazed lunatic, roaming the countryside, committing unspeakable acts, and foaming at the mouth come to mind? Do you think of serial killers like Ted Bundy or Jeffrey Dahmer? Unfortunately, these are the images that come to mind for many when most people think of a psychopath or the word *psychopathy*. However, psychopathy encompasses much more than these sensational images. Psychopaths don't just commit some of the most heinous criminal acts we can think of and end up in prison. They may live in the house down the street. They may work in the cubicle next to you or even serve as your elected representative. As Robert Hare's (1999) book stated, even in the title itself (*Without Conscience: The Disturbing World of the Psychopaths Among Us*), psychopaths may truly interact in all aspects of our society. Nonetheless, psychopathy is increasingly relevant to forensic psychology. As Edens (2006) states, "at some point in their careers, clinicians who work or consult in forensic and correctional settings will almost certainly encounter individuals who exhibit psychopathic personality features" (p. 59). Furthermore, Hemphill and Hare (2004) state that psychopathy is the most important clinical construct in the criminal justice system and therefore it is important to any discussion of forensic psychology.

The Nature of the Psychopath

The term *psychopathy* has a long and varied history that goes back hundreds of years and even has been equated with overall psychopathology or mental illness (Curran & Mallinson, 1944). Millon, Simonsen, Birket-Smith, and Davis (1998) even identify psychopathy as the first personality disorder ever recognized. However, psychopathy is now used to specify a clinical construct or a specific form of **antisocial personality disorder** (APD; Table 4.1) that is prevalent in individuals who commit a variety of criminal acts and generally behave irresponsibly (Hemphill & Hart, 2003). Robert Hare (1996) has described psychopathy as a socially devastating disorder and that psychopaths are intraspecies predators. However, psychopathy should not simply be equated with criminal behavior (Hare, 2001). Despite the general consensus that psychopathy is related to antisocial behavior, there has been a great deal of debate about the criteria and boundaries of psychopathy (Hare, 1996). Some of the debate is apparent in the disagreement about which term best captures the idea we are trying to understand. Is antisocial personality disorder, dissocial personality, sociopathy, or psychopathy the best term? Part of the debate occurs as we try to identify and understand the true nature of psychopathy.

There is more consistency regarding the traits that comprise psychopathy now compared to 70 years ago, despite the continued debate over the origin and course of the disorder (Hare, 2001). Hervey Cleckley (1941) was one of the first scholars to offer a comprehensive and definitive conceptualization of psychopathy in his book, *Mask of Sanity*. Cleckley (1941) identified 16 different characteristics that define or compose the clinical profile of the psychopath. The characteristics included: (1) superficial charm and good intelligence; (2) absence of delusions and other signs of irrational thinking; (3) absence of nervousness; (4) unreliability; (5) untruthfulness and insincerity; (6) lack of remorse or shame; (7) inadequately motivated antisocial behavior; (8) poor judgment

Table 4.1. DSM-IV TR Diagnostic Criteria for Antisocial Personality Disorder

A pervasive pattern of disregard for and violation of the rights of others occurring since age 15, as indicated by three (or more) of the following:

1. failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest;
2. deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure;
3. impulsivity or failure to plan ahead;
4. irritability and aggressiveness, as indicated by repeated physical fights or assaults;
5. reckless disregard for safety of self or others;
6. consistent irresponsibility, as indicated by repeated failure to sustain steady work or honor financial obligations; and
7. lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

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Figure 4.1. Robert Hare is one of the foremost experts on modern psychopathy and the author of the most frequently used measure of psychopathy, the Psychopathy Checklist-Revised.

and failure to learn from experience; (9) pathological egocentricity and incapacity for love; (10) general poverty in major affective reactions; (11) specific loss of insight; (12) unresponsiveness in general interpersonal relations; (13) fantastic and uninviting behavior with drink and sometimes without; (14) suicide rarely carried out; (15) sex life interpersonal, trivial, and poorly integrated; and (16) failure to follow any life plan. Cleckley's (1941) conceptualization was the basis for much of Robert Hare's more recent work (Hare, 1996).

A Popular Operationalization of Psychopathy: The Psychopathy Checklist

Robert Hare (see Figure 4.1) is often credited as the source of the explosion of psychopathy research over the past several decades because of his creation of the most widely used measure of psychopathy, the Psychopathy Checklist (PCL) and the current Psychopathy Checklist-Revised (PCL-R). A fundamental problem in the study of the psychopathy until the 1980s was the lack of a standard method for assessing psychopathy, which made it difficult, if not impossible, to compare results across studies (Hare & Neumann, 2006). The PCL and PCL-R gave the field a common description and method for assessing psychopathy. Although the PCL-R is not the only measure of psychopathy, it has become the standard. Nonetheless, use of a single measure to define

a construct is not without potential problems. As the PCL-R is frequently the default measure to assess psychopathy, the discussion of psychopathy will be largely confined to research using the PCL-R or one of its derivatives such as the Psychopathy Checklist: Screening Version (PCL:SV) and Psychopathy Checklist: Youth Version (PCL:YV).

The PCL-R is composed of 20 items (see Table 4.2) that can be divided into two groups or statistically derived factors. The word *checklist* is a little bit of a misnomer in the name of the PCL-R because it is not simply a list of items that forensic psychologists check off as being either present or absent. A quick look at Table 4.2 and Cleckley's list of psychopathic symptoms suggest several similarities between his original conceptualization and the dominant method for assessing psychopathy. The PCL-R is actually

Table 4.2. A Comparison of Items on the PCL-R and Cleckley's Characteristics

PCL-R items	Cleckley's characteristics
Overlapping items	
1. Glibness/superficial charm—Factor 1	1. Superficial charm and good intelligence
2. Grandiose sense of self-worth—Factor 1	2. Pathological egocentricity and incapacity for love
3. Pathological lying—Factor 1	3. Untruthfulness and insincerity
4. Lack of remorse or guilt—Factor 1	4. Lack of remorse or shame
5. Shallow affect—Factor 1	5. General poverty in major affective reactions
6. Callous/lack of empathy—Factor 1	6. Unresponsiveness in general interpersonal relations
7. Promiscuous sexual behavior	7. Sex life interpersonal, trivial, and poorly integrated
8. Lack of realistic, long-term goals—Factor 2	8. Failure to follow any life plan
9. Impulsivity—Factor 2	9. Poor judgment and failure to learn from experience
10. Irresponsibility—Factor 2	10. Unreliability
11. Failure to accept responsibility for actions—Factor 1	11. Specific loss of insight
12. Criminal versatility	12. Inadequately motivated antisocial behavior, fantastic and uninviting behavior with drink and sometimes without
Non-overlapping items	13. Absence of delusions and other signs of irrational thinking
13. Need for stimulation – Factor 2	14. Absence of nervousness
14. Conning/manipulative – Factor 1	15. Fantastic and uninviting behavior with drink and sometimes without
15. Parasitic lifestyle – Factor 2	16. Suicide rarely carried out
16. Poor behavioral controls – Factor 2	
17. Early behavioral problems – Factor 2	
18. Many short-term marital relationships	
19. Juvenile delinquency – Factor 2	
20. Revocation of conditional release – Factor 2	

a list of 20 symptoms that requires expert clinical judgment to score. Each item is scored on a 3-point scale ranging from 0 to 2. A score of 0 indicates the absence of a symptom, 1 indicates the possible presence of an item, and a 2 is scored if the symptom is definitely exhibited by the examinee. The PCL-R is normally scored through both a review of collateral information and a semi-structured interview. Although the PCL-R can be scored based only on a review of collateral information for research purposes, a clinical interview is recommended, especially for clinical and legal purposes.

Because the PCL-R is scored from 0 to 2 on the 20 items, scores range from 0 to 40 on the measure. A score of 30 and above is considered a conservative cutoff for psychopathy, though some studies have found that scores as low as 25 are appropriate (e.g., Guy & Douglas, 2006). The PCL-R, and psychopathy in general, has been used as a categorical variable; either you are not a psychopath (a score under 30) or you are a psychopath (score of 30 and above). It also has been used as a continuous variable so that the higher the score someone receives, the more psychopathy they exhibit. This distinction has characterized a debate in forensic psychology as to whether psychopathy is best understood as a categorical construct or whether it should be thought of as a continuous score (Edens, Marcus, Lilienfeld, & Poythress, 2006).

Most of the items on the PCL-R are grouped into two categories or factors that were statistically identified as related to psychopathy but separate from one another. These two factors serve as an important distinction for our current understanding of psychopathy. Factor 1 consists of 8 items (as shown on Table 4.2) such as glibness and superficial charm, a grandiose sense of self-worth, pathological lying, as well as others. Factor 1 is often labeled as the interpersonal/affective factor because it is composed of items that largely relate to interpersonal behavior and emotional expression. Factor 2 is often labeled as the socially deviant/antisocial lifestyle factor and consists of behaviorally based items such as parasitic lifestyle, impulsivity, and juvenile delinquency. Three items do not load statistically on either factor, though they are still used to derive a total score on the PCL-R.

In the most recent edition of the PCL-R manual (Hare, 2003), the original two-factor model was expanded to divide the two factors into four facets, two per each factor. Factor 1 is further divided into an Interpersonal and an Affective facet. Factor 2 is further divided into an Impulsive Lifestyle facet and an Antisocial Behavior facet. It is this final facet, Antisocial Behavior, that has come under increasing scrutiny. Cooke and Michie (2001) first suggested that a three factor model was a more accurate conceptualization of psychopathy: Arrogant and Deceitful Interpersonal Style, Deficient Affective Experience, and Impulsive and Irresponsible Behavioral Style. The three factor approach is not interesting because of the ultimate number of factors but because six of the seven items from the PCL-R that did not seem to define a core feature of psychopathy were items related to criminal behavior. In fact, the reduced emphasis on criminal behavior is not something new to our understanding of psychopathy and was even a part of Cleckley's original conceptualization. Some have argued that our inclusion of criminal behavior as a core part of psychopathy may be related to the fact that the PCL-R was developed and primarily used in a criminal population over the last 30 years.

Nonetheless, these different categories, factors, or facets of psychopathy do not differentiate different types of psychopaths; there are not Factor 1 and Factor 2 psychopaths, though the field continues to examine the heterogeneity of psychopathy and has started to question some of our recently held assumptions such as criminality being a core component of psychopathy. One distinction between different types of psychopathy has been the difference between primary psychopathy and secondary psychopathy. **Primary psychopathy** has been characterized as prototypical psychopathy. The primary psychopath commits antisocial acts, is irresponsible, lacks empathy, and is superficially charming because of some inherent deficit (Skeem, Johansson, Andershed, Kerr, & Louden, 2007). **Secondary psychopathy** in contrast is not inherent but instead is caused by "social disadvantage, low intelligence, neurotic anxiety, or other psychopathology" (Newman, MacCoon, Vaughn, & Sadeh, 2005, p. 319). In fact, the key distinction between primary and secondary psychopathy has been the presence of anxiety in the secondary psychopath (Schmitt & Newman, 1999). It has been argued that the secondary psychopath commits antisocial behavior out of impulsivity that is driven by anxiety. It is the absence of any anxiety that has generally characterized the true psychopath and allows him to commit his violence and antisocial behavior repeatedly and without conscience (Levenson, Kiehl, & Fitzpatrick, 1999). More recent reviews question whether the distinction between primary and secondary psychopathy is one supported by the empirical literature at this time and whether it is a beneficial difference in terms of clinical practice and policy decisions (Skeem, Polaschek, Patrick, & Lilienfeld, 2011). However, the difference between primary psychopathy and secondary psychopathy has not been the only issue in need of distinction in regard to psychopathy.

Many students and even psychologists question the difference between psychopathy and the more common term, antisocial personality disorder (APD). Although these two constructs are related and in fact the correlation between psychopathy and APD is large, ranging from .55 to .65 (Hemphill & Hart, 2003), there are also several important differences that distinguish APD from psychopathy (Bodholdt, Richards, & Gacono, 2000).

First, APD is listed in the most widely accepted sources for mental illnesses, the *Diagnostic and Statistical Manual-IV Text Revised* (DSM-IV TR) and in the 10th edition of the *International Classification of Diseases* (ICD-10) as dissocial (antisocial) personality disorder. Psychopathy is not officially listed in the DSM-IV TR or the ICD-10 as a disorder with the accompanying diagnostic criteria. However, the characteristics that compose psychopathy are listed in the associated features of DSM-IV TR, and the term *dissocial personality disorder* is used in the ICD-10 to refer to a construct similar to psychopathy (Hemphill & Hart, 2003).

Another difference between APD and psychopathy is related to the diagnostic criteria listed in the DSM-IV TR. The diagnostic criteria for APD are very behavioral (Table 4.2). By behavioral, I mean that DSM-IV TR tries to increase the reliability of antisocial personality disorder by confining the diagnostic criteria to very objective behaviors such as lying, cheating, and stealing. However, psychopathy is not defined only in behavioral terms, as identified in Factor 2, but also by the interpersonal/affective characteristics that comprise Factor 1. These Factor 1 items may be more difficult

to assess than the Factor 2 items. As a result, it is argued that a diagnosis of psychopathy is narrower and more specific than APD. However, the release of DSM-5 in May 2013 did alter these criteria and some of the conceptualization of APD according to DSM.

Accordingly, there are also different prevalence rates for psychopathy and APD. About 3% to 5% of the general public can be diagnosed with antisocial personality disorder and about 50% to 80% of incarcerated offenders. However, only about 1% of the general public suffers from psychopathy and research suggests that only 25% or a range of 15% to 30% of incarcerated offenders are psychopaths (see Figure 4.2). As a result, psychopathy has a much lower prevalence in both the general public and among criminal offenders. APD is often criticized as a diagnosis among offenders because it has little meaning when most offenders can be diagnosed with the disorder. As Bodholt, Richards, and Gacono (2000) state, identifying APD "in forensic settings is something like finding ice in your refrigerator" (p. 59). Furthermore, not all people who suffer from psychopathy also suffer from APD. Only about 90% of psychopaths suffer from APD, whereas about 15% to 30% of those with APD suffer from psychopathy (Hemphill & Hart, 2003). Individuals who are psychopaths but do not suffer from APD are often referred to as **successful psychopaths**. Successful or white-collar psychopaths are not incarcerated and tend to exhibit higher intelligence, are more educated, and are from a higher socioeconomic standing than most psychopaths. Successful psychopaths tend to be found working in corporations or holding political office (Hare, 1999). See Box 4.1 for a discussion of successful psychopaths. This conceptualization of successful psychopaths and the notion that criminal behavior may not be a core element of psychopathy, but only a manifestation of it, are related to our evolving understanding of the construct.

Use of the PCL-R in the Practice of Forensic Psychology: Field Research

It is a necessity for a forensic psychologist to examine the literature on a given forensic practice. However, one issue that we are increasingly thinking about is the performance of some of our measures and techniques in the actual practice of forensic psychology.

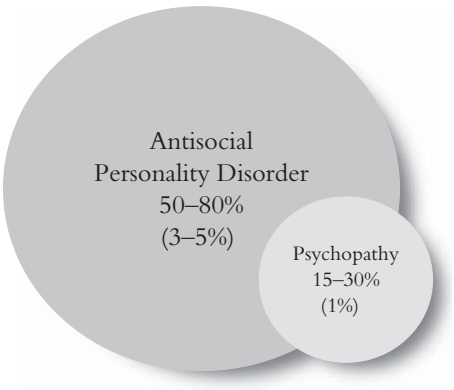

Figure 4.2. The Prevalence and Relationship of Psychopathy and Antisocial Personality Disorder

Box 4.1. Snakes in Suits: Successful Psychopaths

Nearly all of the research conducted on psychopaths has focused on criminal offenders. The primary reason is that criminal offenders present a captive and easily accessible audience for study. However, noninstitutionalized studies of psychopaths are nothing new to psychopathy. In fact, one of the earliest studies in psychopathy, prior to the advent of the PCL-R, focused on noninstitutionalized samples and obtained noninstitutionalized subjects in a very creative manner. Cathy Widom (1976) placed an ad in the classified section of a Boston newspaper under the guise that she was looking for adventurous people to participate in a psychological study. The ad itself read like a list of the characteristics of psychopaths and resulted in Widom getting almost 30 people to participate whom she identified as potential psychopaths.

Excluding Widom's pioneering study, very few studies have attempted to assess noninstitutionalized psychopaths outside of college samples. However, Paul Babiak and Robert Hare have begun to examine noninstitutionalized or successful psychopaths. Specifically, they have pointed to the business world as a source of potential psychopaths and have used the phrase *snakes in suits* in the title of their recent book, *Snakes in Suits: When Psychopaths Go to Work* (2006). Jobs like used-car salesman and politician may be ideal for psychopaths. For example, Michael Douglas's character in the movie *Wall Street* may be an example of a successful psychopath. However, many of their conclusions about successful psychopaths are not based on empirical studies but are purely anecdotal. Only future research will really tell us whether psychopathic individuals are truly as widespread as they suggest.

This is an issue that we will continually address throughout the book beginning with the use of the PCL-R. The PCL-R has continually demonstrated appropriate reliability and validity when the intent was to use it for research purposes (Hare, 2003). The question remains whether it will do so in field settings and whether there are any extraneous factors that may affect scores. In one of the initial studies by Murrie, Boccaccini, Johnson, and Janke (2008), they examined PCL-R scores from independent forensic psychologists who were retained by opposing sides. They found that score differences were greater than would be expected and that the differences were usually in the direction that favored that particular side. For example, experts retained by the prosecution were significantly higher than those assigned by defense experts. These results were then supported in an expanded study (Boccaccini, Turner, & Murrie, 2008). In another study looking at the ability of the PCL-R to predict recidivism in a field sample, PCL-R scores did not predict recidivism (Murrie, Boccaccini, Caperton, & Rufino, 2012). However, Murrie et al. (2008) found that a given psychologist's experience in administering the PCL-R was associated with the psychologist's predictive ability; a subsample of forensic psychologists who had scored the most PCL-Rs were the most successful at predicting recidivism. Despite these differences, evaluators from the defense and the state appear to be equal in their ability to detect future recidivism (Boccaccini, Turner, Murrie, & Rufino, 2012). These findings as a whole suggest that there are differences in scoring the PCL-R for research purposes compared to forensic

practice. Nonetheless, the results should not be taken as an indictment of the PCL-R but should encourage more critical evaluation of PCL-R scores and more careful scoring on the part of forensic psychologists in the field.

The Relationship of Criminal Behavior and Violence to Psychopathy

The distinction between APD and psychopathy is not sufficient to understand the true nature of the psychopath. Since the widespread use of the PCL-R, criminal behavior has been at the heart of psychopathy, specifically violent criminal behavior. Although there are a number of interpersonal, learning, cognitive, and physiological bases for the expression of violence, it is the violence of the psychopath that routinely captures the imagination of the public and forensic psychologists.

General Violence and Criminal Behavior

Almost since the inception of the PCL-R, its relationship with criminal behavior and violence was explored. The growth in the field is largely a result of this relationship (Edens, 2006). It makes sense that because criminal offenders are most likely to be the subject of studies examining psychopathy that the focus would often be on the relationship between past and future criminal behavior. It should not be surprising that research has consistently found a relationship between psychopathy and several forms of criminal behavior. In fact, psychopathy has been called the single biggest factor in the assessment of future violence (Salekin, Rogers, & Sewell, 1996), and though not necessary, psychopathy may be sufficient in assessing risk in certain circumstances (Hemphill & Hart, 2003). With the expansion of the study of psychopathy in the past 20 years, there have been an abundance of research studies and several meta-analyses focusing on the relationship with criminal behavior.

The first meta-analysis examining the relationship between psychopathy and criminal behavior was by Salekin et al. (1996). Studies examining criminal behavior typically use criminal recidivism, or repeat criminal behavior, as an indication of criminal behavior. Salekin et al. (1996) found a significant relationship between psychopathy and general criminal recidivism and an even larger relationship between psychopathy and violent recidivism. Hemphill, Hare, and Wong (1998) took it one step further with a slightly larger group of studies and found a significant but equal relationship with general recidivism and violent recidivism. They found that Factor 2 was a better predictor of general recidivism but that Factor 1 and 2 predicted violent recidivism equally well. Additional meta-analyses have found similar results (Gendreau, Goggin, & Smith, 2002; Walters, 2003b). The available evidence generally suggests that psychopaths are more likely to commit nonviolent crimes and violent crimes than non-psychopaths. But what else do we know about the violence of psychopaths compared to non-psychopaths?

It is a widely held belief that as we age we are less likely to act out antisocially. In fact, 40 years has often been identified as a threshold age when offenders are likely to

burn out or show a sharp decrease in their criminal behavior (Huss & Langhinrichsen-Rohling, 2000). This general reduction in crime may be an accurate portrayal of non-violent criminal behavior but not violent criminal behavior in psychopaths (Hare, McPherson, & Forth, 1988). Psychopaths appear to continue to commit higher rates of violence than non-psychopaths even after the age of 40 (Harris, Rice, & Cormier, 1991). They may even display greater emotional violence (Heilbrun et al., 1998). However, Edens suggests that the available information is not sufficient for forensic psychologists to make definitive conclusions in court concerning the lack of a reduction in violence in psychopaths after age 40 (Edens, 2006; Edens, Petrila, & Buffington-Vollum, 2001).

Another distinction in the violent behavior of psychopaths has been the general nature of their violence. One aspect of psychopathic violence has been the difference between instrumental and reactive violence. **Instrumental violence** is violence that is pursued with a clearly defined goal or that is planned, and **reactive violence** is perpetrated out of emotion. If you are planning to murder your wife or partner because you want to collect some insurance money, you are exhibiting instrumental violence. If you come home and find your wife or partner in bed with the mailman and in a fit of anger you pick up the pet rock you have sitting on the dresser and proceed to bash the mailman over the head with it, you are exhibiting reactive violence. The belief has long been held that psychopaths are more likely to perpetrate instrumental violence than other non-psychopaths or other offenders in general (Cleckley, 1941). More current research has largely validated these theoretical beliefs. Williamson, Hare, and Wong (1987) found that psychopaths were more likely to perpetrate instrumental violence than non-psychopathic offenders and less likely to have experienced emotional arousal in a Canadian sample of offenders. Cornell et al. (1996) verified these results among U.S. prisoners. In addition, Cornell et al. (1996) concluded that psychopaths are able to inflict serious injury for goal-directed purposes because of their lack of well-socialized norms, guilt, and remorse.

Nonetheless, the relationship between psychopathy and instrumental violence is not completely clear because psychopaths also exhibit several symptoms such as poor behavioral controls that suggest they are more likely to commit reactive or impulsive violence. Even though Williamson et al. (1987) found that psychopaths were significantly more likely to commit instrumental violence than non-psychopaths (42.5% compared to 14.6% of the time), the majority of their violence was reactive. In fact, Hart and Dempster (1997) referred to psychopathic violence as impulsively instrumental. Woodworth and Porter (2002) found that Factor 1 scores but not Factor 2 scores were related to instrumental violence. Therefore it may be that Factor 2, antisocial and deviant features of psychopathy, predicts violence but Factor 1 predicts the nature of the violence and whether it is reactive or instrumental (Porter & Woodworth, 2006).

A number of other features also may distinguish psychopathic violence. Psychopaths are more likely to victimize strangers than are non-psychopaths (Hare, McPherson, & Forth, 1988). Williamson et al. (1987) found in their study that none of the murders committed by psychopaths involved family members compared to 63% of murders among non-psychopaths. Violence committed by psychopaths is more

likely to occur out of revenge and rarely in self-defense (Hart, 1998), which is probably related to the increased likelihood of instrumental violence. Psychopaths' most serious violence is likely to occur during intoxication because they fail to maintain their emotional control when under the influence of alcohol or drugs (Hare, McPherson, & Forth, 1988). A surprising finding is that although psychopaths are more likely to inflict more severe violence than non-psychopaths, they are less likely to murder (Williamson et al., 1987). This finding may occur because murders often result out of an emotionally charged situation and are therefore uncharacteristic of psychopaths. Woodworth and Porter (2002) further found that when psychopaths do commit murder, it is more likely to involve instrumental characteristics (93.3%) than reactive characteristics and that they are almost twice as likely as non-psychopaths (48.4%) to perpetrate a murder that is largely instrumental.

The literature is very clear that psychopathy plays a unique role in the expression of violence. Although psychopaths constitute a minority of criminal offenders, they may account for a disproportionate amount of the violence committed (Huss & Langhinrichsen-Rohling, 2000). Psychopathic violence may have several important characteristics that make it especially problematic and unique compared to most violence. However, the link between psychopathy and the commission of criminal behavior and violence is not simply limited to general offenders but also has been examined in other types of criminal behavior.

Sexual Violence

Although Cleckley (1941) has little to say about the role of sexual aggression in psychopaths, their sexual promiscuity and lack of emotional responsiveness in interpersonal relationships may suggest an increased risk for sexual violence. Several studies have found that psychopathy is predictive of sexual recidivism among rapists and child molesters and is related to sexual arousal in general (Quinsey, Rice, & Harris, 1995; Rice & Harris, 1997; Rice, Harris, & Quinsey, 1990). In fact, offenders with higher scores on the PCL-R commit more frequent and more severe levels of violent sexual offenses (Gretton, McBride, Hare, O'Shaughnessy, & Kumka, 2001). Although the frequency of psychopathy ranges from 15% to 30% among general offenders, about 10% to 15% of child molesters and 40% to 50% of rapists are probably also psychopaths (Brown & Forth, 1997; Porter, Fairweather, Drugge, Hervé, & Birt, 2000; Quinsey et al., 1995). As these statistics suggest, there are differences among sex offenders.

Generally sexual offenders can be divided into those who perpetrate sexual violence against adults (rapists), children (child molesters), and both children and adults (mixed). Knight and Guay (2006) concluded in their review of the literature that psychopaths are more likely to commit rape and are overrepresented in samples of rapists. Quinsey et al. (1995) found a higher prevalence of psychopathy in rapists than child molesters. Porter, Campbell, Woodworth, and Birt (2001) found that rapists and mixed group offenders had higher scores on the PCL-R than child molesters and that offenders who sexually victimized both children and adults were up to 10 times more likely than other

offenders to be psychopaths (Porter, Campbell, Woodworth, & Birt, 2002). Porter et al. (2000) also found that mixed rapists/molesters had the highest Factor 1 scores, suggesting an increased level of insensitivity and callousness. In fact, most offenders who perpetrate on both children and adults are psychopathic (Rice & Harris, 1997). Porter et al. (2000) even suggested that sexual psychopaths could be designated a distinct category of sexual offenders.

Violence in Civil Psychiatric Patients

It makes sense that psychopathy is important in the expression of violence among general offenders and sex offenders, but what about a population in which the expression of violence is not as high? As we will discuss in a later chapter, an individual found to be mentally ill and dangerous may be hospitalized via civil commitment in order to protect others from any potential violence. Nonetheless, the risk of violence among civil psychiatric patients is much lower than general offenders and the importance of psychopathy among civil psychiatric patients is less obvious. Skeem and Mulvey (2001) conducted one of the early examinations of psychopathy in a sample of civil psychiatric patients. They found that even in this less violent sample that psychopathy was a strong predictor of violence. The importance of psychopathy as a predictor of violence in civil psychiatric samples has been duplicated in other studies (Douglas, Ogloff, Nicholls, & Grant, 1999; Nicholls, Ogloff, & Douglas, 2004).

Violence among Domestic Violence Perpetrators

Domestic violence is another type of violence that has been examined for a potential relationship with psychopathy. Although the perpetration of domestic violence has often been associated with societal and cultural reasons for violence, some have suggested an important role for psychopathy (Huss, Covell, & Langhinrichsen-Rohling, 2006; Spidel et al., 2007). Recent studies have examined the presence of psychopathy among criminal offenders with domestic violence histories (Grann & Wedin, 2002; Hilton, Harris, & Rice, 2001). Results from both studies suggest that psychopathy is a useful construct in predicting future violence among offenders with a history of domestic violence. However, these studies did not examine domestic violence per se but offenders who had committed domestic violence as one of potentially many crimes. Huss and Langhinrichsen-Rohling (2006) examined psychopathy in a clinical sample of batterers referred for domestic violence treatment and found little predictive relationship between psychopathy and domestic violence above antisocial behavior. However, Rock, Sellbom, Ben-Porath, and Salekin (in press) have more recently examined a sample of batterers in treatment and found that psychopathy was related to failure to complete treatment in a group of 483 batterers. Rock et al. used the Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF) as a way to estimate psychopathy scores though it is not a well-accepted measure of psychopathy. As a result, the relationship between psychopathy and domestic violence is less clear than for other types of violence.

What Else Do We Know about Psychopathy?

It is also important to remember that though psychopathy may be the most robust predictor of violence across a variety of types of violence, the PCL-R is not intended to be a risk assessment measure. In Chapter 5, we will examine measures designed specifically to assess future violence. In fact, a more recent study suggested that the PCL-R was the poorest predictor of a host of risk assessment tools (Singh, Grann, & Fazel, 2011). This finding should only emphasize the reason the PCL-R should not be considered a risk assessment measure but a diagnostic tool for psychopathy (Hart, 1998). Psychopathy, as it is currently conceptualized, just happens to be a good predictor of violence. In addition to the violence and criminal behavior associated with psychopaths, we also have accumulated a great deal of information about the reasons for the behavior of psychopaths. Some of this information is similar to Cleckley's original conceptualization, but much of it explains some of their potentially contrasting behavior that was simply a mystery before. Even though the information is less applied than the discussion so far, it is still important for forensic psychologists to be aware of this research in attempting to explain psychopathic behavior.

Interpersonal-Affective Aspects of Psychopathy

By examining the list of Factor 1 items, it is easy to understand that interpersonal and emotional deficits are central to understanding psychopathy. Characteristics such as glibness and superficial charm, a grandiose sense of self-worth, pathological lying, conning and manipulativeness, lack of remorse and guilt, shallow affect, callous lack of empathy, and failure to accept responsibility for one's actions are going to play a significant role in one's ability to interact and maintain relationships with other people. Psychopaths may be great to introduce at a party or act as a media spokesperson for a product advertisement. However, you would not want to have to count on a psychopath to come pick you up after your car breaks down or try to get across to him your despair after not getting into graduate school, and you certainly would not want to marry one. These interpersonal and affective deficits impede the psychopath's ability to interact long-term with all other humans.

One of the striking features of psychopaths is their altered emotional or affective responses in their language (Hiatt & Newman, 2006). Psychopaths produce technically correct language that masks or hides their underlying emotional deficits; the experimental evidence has largely supported this notion (Cleckley, 1941). When asked to choose two similar words from a group of three words, psychopaths base their choice on literal meaning whereas non-psychopaths base their decisions on their connotations or their emotional connections (Hare, Williamson, & Harpur, 1988). These results suggest that psychopaths may simply be less sensitive to emotional expression. Further research by Hervé, Hayes, and Hare (2003) suggests that psychopaths have a clear understanding of the specific meaning of words but they tend to ignore or fail to understand the emotional importance of a word.

Interpersonal deficits are even clear in experiments that have focused on more routine tasks that most people engage in over the course of their day. Brinkley, Bernstein, and Newman (1999) asked subjects to generate stories with specific plots. They found that psychopaths made fewer connections between the different elements of the story, which is to be expected of individuals whose language is generally superficial and void of deep meaning. Their characteristic use of language even extends to nonverbal gestures. Gillstrom and Hare (1988) videotaped standard interviews with psychopaths. They found that those who scored higher in psychopathy tended to use fewer hand gestures that were used to illustrate a relevant point to the conversation but used more hand gestures that were unrelated or unintentional to the conversation.

These deficits also are characteristic of the psychopath's emotional expression and their reduced understanding of emotion in general. Psychopaths have difficulty processing or understanding emotions, as demonstrated by a failure to exhibit any differences between peripheral information and information central to a series of slides (Christianson et al., 1996). Psychopaths often seem unable or unwilling to process or use the deep semantic meanings of language (Williamson, Harpur, & Hare, 1991). They are superficial, more abstract meanings of language escape them, and they seem to be unable to draw upon affective or emotional words immediately (Williamson et al., 1991). However, if psychopaths are told explicitly to pay attention to peripheral information, they can attend to contextual emotion more accurately (Levenston, Patrick, Bradley, & Lang., 2000). Their emotional deficits are especially relevant to negative emotions such as fear, anxiety, and guilt when considering psychopaths' deviant and antisocial behavior (Day & Wong, 1996). Deficits in these areas probably make it more likely that they are unable to appreciate the emotional impact of their behaviors on victims (Patrick, 1994).

Psychopaths are said to lack a deep understanding of emotions and may only experience quasi-emotions (Steuerwald & Kosson, 2000). A well-known expression in describing the emotional or affective response of psychopaths is that they understand the words to the music but they don't feel the beat. For example, psychopaths may understand the dictionary definitions of words like *despair*, *excitement*, *fear*, and *anxiety* but they may lack experience with those emotions that would enable them to truly understand them. It is as if they may be able to understand the words to a song but are unable to feel the beat of the music and have trouble dancing to it. Evidence pointing to an affective deficit in psychopaths does not mean they don't show emotions. Psychopaths may routinely express an emotion such as anger (Steuerwald & Kosson, 2000) but these emotions are often referred to as pseudo or **sham emotions**. These emotions are typically used to control an individual or a situation, not to express any genuine emotion (Hare & Hart, 1996). It is still not ultimately clear whether these emotional differences are due to an absence of emotion, a failure to process emotions automatically, or a lessened degree of emotional experience. However, it is clear that there are differences between psychopaths and non-psychopaths in their affective and interpersonal abilities.

Cognitive and Learning Deficits Associated with Psychopathy

Another prominent characteristic of psychopathy is cognitive and learning deficits. The belief that psychopaths are simply unable to learn from their mistakes extends at least to Cleckley's early description. Even if psychopaths have difficulty learning from their mistakes, they generally have intact abilities in many areas of cognitive functioning such as intelligence and memory (Hiatt & Newman, 2006). Research has verified that psychopaths have a cognitive limitation in terms of learning but that this limitation is more complex than first thought (Newman, 1998). Psychopaths do not simply have a general deficit in learning but instead have a very specific deficit that is expressed as a problem with passive avoidance learning (Patterson & Newman, 1993). **Passive avoidance learning** is an inability to learn from behaviors that punish. Studies fairly consistently have shown that psychopaths have an inability to learn from punishment or even declining reinforcement, whether experimenters use loud noises, electrical shocks, or financial incentives (see Patterson & Newman, 1993, for a review).

Furthermore, it appears that these deficits are not the result of a simple failure to learn from punishment or even relate to their general impulsiveness. They are more likely hypersensitive to rewards and this hypersensitivity can result in a narrowed attentional focus (Kosson, 1996). Several studies have found evidence of the narrowed attentional focus of psychopaths using Stroop tests or Stroop-like tasks. A Stroop test is a common cognitive test in which a person is shown a list of words that represent colors (red, green, blue, etc.) but the words also appear in different colors. The person is then asked to name the color each word is printed in according to the paper or slide. If the words themselves match the color they are printed in, the task is easy. However, if the word *red* is printed in green and the word *green* is printed in yellow, the task becomes much more difficult for most people, who have difficulty blocking out the peripheral word and paying attention only to the color of the ink. However, psychopaths do not have this same difficulty. Because of their narrowed attention focus, psychopaths actually perform better on Stroop-like tasks than non-psychopaths (Newman, Schmitt, & Voss, 1997).

One obvious extension of these potential deficits is the degree to which they impact moral reasoning. As the title of one study asked, can psychopathic offenders discern moral wrongs (Aharoni, Stinnott-Armstrong, & Kiehl, 2012)? The answer to this question would have significant legal ramifications, despite the presence of psychopathy typically being ruled out as a potential legal defense or mitigating circumstance in criminal cases. Cleckley long argued that a deficit in moral reasoning lay at the heart of the disorder and that psychopaths were unable to tell the difference between right and wrong. Research by Blair and colleagues found that psychopaths did not differentiate between conventional and moral wrongs, seeing both as equally impermissible (Blair, 1995; Blair, Jones, Clark, & Smith, 1995). However, more recent evidence has called into question whether there is a sufficient empirical basis to conclude there are moral reasoning deficits among psychopaths. Aharoni et al. (2012) found that psychopathy

scores did not predict performance on a moral reasoning task but that it was better explained by factors such as IQ scores.

Biological Basis for Psychopathy

Although it is clear so far that psychopaths exhibit interpersonal emotional and cognitive deficits, the biological basis for these outward expressions of psychopathy are not as clear. Studies have found a genetic basis for psychopathy as well as brain differences (Vitale & Newman, 2008). However, psychopaths have consistently demonstrated characteristic physiological responses. For example, psychopaths exhibit a reduced fear in anticipation of unpleasant or painful stimuli using physiological measures such as heart rate and skin conductance (Hart, 1998). However, studies are not completely consistent, depending on the context of the experiment and the precise nature of the experimental stimuli (Margolin, Gordis, Oliver, & Raine, 1995). Blair, Jones, Clark, and Smith (1997) offer an interesting distinction. They presented participants with two different stimuli, distressful (e.g., a group of crying adults) and threatening (e.g., a coiled up snake). Results revealed that psychopaths exhibited reduced skin conductance when exposed to distressful stimuli but no differences under threatening or neutral conditions (Blair et al., 1997). In general, research suggesting differences in the physiological responses of psychopaths have pointed to these findings as a biological basis for the psychopaths' inability to experience fear and anxiety and their heightened ability to maintain control in anxiety-provoking situations.

In addition to these physiological differences, there is also neurobiological evidence suggesting differences in the brains of psychopaths and non-psychopaths (Hare, 2001). Although there do appear to be specific neurobiological differences in psychopaths, they do not exhibit global neuropsychological deficits (Hart, Forth, & Hare, 1990). Hart et al. (1990) administered a standard screening battery of neuropsychological tests in two samples of participants divided into low, medium, and high psychopathy. Results revealed no differences across the three groups. Failure to identify differences using neuropsychological batteries does not give definitive proof that there are no differences, but it does tend to suggest differences may be functional rather than structural (Hare, 2001). Structural biological differences refer to differences in the size and shape of the brain structure, whereas functional differences refer to differences in how these structures of the brain interact or function with one another. As a result of the possibility of functional differences, researchers have continued to search for an underlying neurobiological basis for the emotional and cognitive deficits of the psychopath.

Evidence for functional differences in the brains of psychopaths has largely been based on studies employing brain imaging that enables real-time pictures of the brain. Intrator, Hare, Stritzke, and Brichtswein (1997) used single photon emission computed tomography (SPECT) to study the blood flow in the brains of psychopaths, while presenting participants with emotional and neutral words. The study revealed that the brains, specifically the cerebral cortexes, of psychopaths are less active and that activation is largely confined to the occipital cortex, whereas non-psychopaths

showed much more activity in the other cerebral cortexes. This finding suggests that psychopaths are processing the information visually (using the occipital lobe) but that they may not be doing much more with it. Several studies using another imaging technique, functional magnetic resonance imaging (fMRI), also support the notion that psychopaths fail to use certain parts of the brain (i.e., frontal cortex, limbic system, amygdala) when they are processing emotional stimuli (e.g., Kiehl et al., 2004). These results have been described as being similar to a parked car with someone stepping on the accelerator. There is a lot of activity in certain regions of the brain, much like the engine of the car, but without the ability to process this information at a deeper level in the frontal lobe or subcortical structures like the amygdala, the information is not useful, just as a parked car is not useful in getting to the grocery store. These studies have begun a rapidly developing trend in psychopathy research—the use of a variety of brain imaging techniques. More recent studies have converged to suggest the amygdala, the prefrontal cortex, and extended paralimbic structures are most relevant (Anderson & Kiehl, 2012) and that they may even have implications for psychopathic subtypes such as primary and secondary psychopathy (Motzkin, Newman, Kiehl, & Koenigs, 2011).

Treatment of Psychopathy

Controversy has continually surrounded the treatment of psychopaths, specifically whether as a group they were likely to respond to treatment. Forensic psychologists have been pessimistic about the treatment of psychopaths. For example, Cleckley (1941) believed that psychopaths did not have the ability to form the emotional attachments necessary for effective psychotherapy and therefore would not benefit from it. Cleckley's pronouncement has been very characteristic of the perceived treatability of psychopaths. This belief is so widely held that I once had a supervisor tell me there was only one effective therapy for psychopaths—magnum therapy. She made this statement as she pulled her finger out of her pocket and shot it like a magnum pistol at her temple. Despite this controversy and maybe because of the pessimism, there have been few studies examining the treatment response of psychopaths, especially using the most recognized measure of psychopathy, the PCL-R (Harris & Rice, 2006).

Early studies using the PCL-R as a standard measure of psychopathy seemed to support the original pessimism. Ogloff, Wong, and Greenwood (1990) conducted a study on 80 federal inmates enrolled in a treatment program. Their results consistently demonstrated that psychopaths demonstrated less clinical improvement, were less motivated, and left the program earlier than non-psychopaths. Rice, Harris, and Cormier (1992) conducted a study examining 176 offenders from a forensic facility who were enrolled in a novel treatment program. They found that not only did treated psychopaths not get any better, they got worse! This study has been used as an indication that not only does treatment fail for psychopaths but the wrong treatment approach can actually make psychopaths better psychopaths by giving them insight into the emotions of others (Huss & Langhinrichsen-Rohling, 2000).

Box 4.2. Focus on Research: Be Careful What You Wish for in the Treatment for Psychopaths

Rice, Harris, and Cormier's 1992 study is one of the most often cited studies on psychopathy. In fact, it was referenced, though incorrectly, repeatedly in the final season of the television show, *The Sopranos*, as proof that psychopaths get worse in therapy. In their study, Rice and colleagues found that 22% of the non-psychopaths who were treated violently recidivated after they were released compared to 39% of the untreated non-psychopaths. This outcome was certainly expected; one would hope that treatment is effective. However, their findings regarding psychopaths were quite surprising and have been heralded ever since as an indication that treating psychopaths is a much different matter. They found that 55% of the untreated psychopaths violently recidivated but that 77% of the treated psychopaths became violent after they were released. It was not just that treatment did not work but that the treatment made them worse! This study was immediately heralded as evidence to support the long-held notion that psychopaths do not respond to conventional psychological treatment.

However, the problem was that the treatment was anything but conventional. The treatment unit where these offenders were being held employed a fairly unconventional form of treatment called *defense disrupting therapy*. The treatment tended to be very intense. More interesting was that it included nude encounter sessions that lasted as long as two weeks. Staff also forced offenders to use drugs such as LSD and alcohol during treatment sessions (D'Silva et al., 2004). Obviously, generalizing the results of such an unconventional treatment to all treatment of psychopaths is problematic.

However, the particular treatment employed at this facility was very unconventional (see Box 4.2) though it was mentioned during one season of a long-running television show, *The Sopranos*.

However, this view is beginning to be challenged, if not contradicted. Salekin (2002a) conducted a meta-analysis on the available studies focusing on the treatment of psychopathy. He concluded that the widely held belief that psychopaths did not respond to treatment was unfounded and that psychopaths can benefit from treatment. However, Salekin (2002a) has been criticized for the over-inclusiveness of studies in his meta-analysis, especially studies that did not use the PCL-R as the measure of psychopathy (Harris & Rice, 2006). Others have said that there is not sufficient evidence to support either contention that treatment is effective or ineffective for psychopaths (Edens, 2006; Harris & Rice, 2006) but a systematic review arrived at the same conclusion as Salekin, focusing on treatment studies only using the PCL-R (D'Silva, Duggan, & McCarthy, 2004). Nonetheless, there may be some hope for the future. Evolving research has shown that treatment can reduce psychopathic offenders' risk factors for recidivism (Olver & Wong, 2009) and one review stated that the default position should not be that psychopaths are untreatable but that they are treatable, until research clearly suggests otherwise (Skeem et al., 2011).

Special Groups and Psychopathy

In reviewing the major issues related to psychopathy, one thing should be clear. The research focusing on violence, interpersonal-affective deficits, cognitive-learning deficits, and treatment has largely been based on a narrow group of psychopaths. The studies have largely been conducted using institutionalized, adult, Caucasian men from Canada and the United States. As a result, a scope of practice question arises. In what other groups is it appropriate to use the PCL-R or use psychopathy as an important factor in assessing risk? In this section I discuss some of the research regarding psychopathy in more diverse groups in order to get a more comprehensive view of the extent of psychopathy.

Women

Although Cleckley (1941) originally included women in his discussion of psychopathy, women have been largely ignored in the study of psychopathy. As their presence in our jails and prisons grows, the role of psychopathy among them has been increasingly examined. The study of psychopathy among women is especially important because of the consistent finding that there are significant differences in the prevalence and expression of externalizing (substance abuse, antisocial personality disorder) and internalizing (depression, anxiety) disorders between men and women (Robins & Regier, 1991). As a result, researchers have begun to examine the prevalence, behavioral manifestations, and clinical correlates of psychopathy in women and found some similarities but also some differences with their male counterparts.

Reviews of the literature on women and psychopathy have generally found lower prevalence rates than with men (Verona & Vitale, 2006; Vitale & Newman, 2001). The lower prevalence rates should not be surprising since this finding is consistent with the prevalence of disorders like antisocial personality disorder and conduct disorder. As discussed before, the prevalence rates of psychopathy in incarcerated men range from 15% to 30%, but 25% is typical. Women exhibit similar, though more varied, levels (Verona & Vitale, 2006). Studies have found prevalence rates higher than 30% (Louth, Hare, & Linden, 1998) and as low as 9% (Vitale, Smith, Brinkley, & Newman, 2002). Research has found not only that fewer women score above the traditional cutoff of 30 but also that women also exhibit lower mean scores on measures of psychopathy than men (Alterman, Cacciola, & Rutherford, 1993; Rutherford, Cacciola, Alterman, & McKay, 1996).

There also appear to be differences in the behavioral manifestations of psychopathy in women. The relationship between psychopathy and aggression is very clear in male psychopaths. However, the findings for women are not as transparent. There have been several studies that have found a relationship between past violent and nonviolent convictions, self-reported violence, and past arrests in women (Vitale et al., 2002; Weiler & Widom, 1996). When Salekin, Rogers, Ustad, and Sewell (1998) focused on the relationship of psychopathy and future recidivism in women, they found only a moderate relationship, at best, and concluded that only Factor 1 of the PCL-R was

related to recidivism. Verona and Vitale (2006) suggest that these inconsistent findings may be because of the differences found in the development of aggression in boys and girls from a young age.

Another important consideration in the examination of psychopathy among women is the underlying clinical presentation of the disorder. Men and women are likely to exhibit certain symptoms in different ways. For example, in terms of violence a male psychopath may get into a bar fight, whereas a female psychopath may be more likely to be violent toward family members and in her own home (see Robbins, Monahan, & Silver, 2003). It may well be that they both have underlying predispositions toward antisocial behavior but that these dispositions are expressed in different ways. In fact, Lilienfeld and colleagues (Cale & Lilienfeld, 2002; Lilienfeld, 1992; Lilienfeld & Hess, 2001) suggest that disorders such as borderline personality disorder, somatization disorders, and histrionic personality disorder may be female expressions of psychopathy because of the significant overlap in these disorders and antisocial behavior. For example, Verona and Vitale (2006) use the movie *Fatal Attraction* and Glenn Close's character as a possible example of this manifestation. In the classic movie, Glenn Close's character is obsessed with Michael Douglas's character to the point of extreme violence. In addition, she is manipulative, conning, impulsive, and lacks empathy and remorse for her behavior that is intended to prevent him from ending their affair and returning to his wife and family. Angelina Jolie's character in *Girl Interrupted* might be another fictional example with similar characteristics. The behavior of either of these two characters is often characterized as indicating borderline personality disorder but it may be that women are more likely to express psychopathic features in this way because of the difference in externalizing versus internalizing behaviors between men and women.

Ethnic and Cross-Cultural Issues

As we became more confident of the nature of psychopathy in Caucasian samples in North America, attention began to turn toward the cross-cultural and multicultural extensions of psychopathy. Hare (2003) concluded a decade ago that the PCL-R is generally appropriate to use with a variety of ethnicities and nationalities. However, there are some limitations and differences in assessing psychopathy outside the foundation for most of the research.

One of the first questions regarding the generalization of psychopathy was its applicability to African Americans, despite their overrepresentation in correctional facilities across the United States. Early efforts at using the PCL-R often excluded African Americans (Kosson & Newman, 1986) because of the lack of reliability and validity of the PCL-R for African American offenders. Kosson, Smith, and Newman (1990) conducted a series of studies in which African Americans were included and found the scores of African American offenders slightly elevated in comparison to Caucasian offenders. However, additional studies have not found the same results consistently (see Sullivan & Kosson, 2006, for a review).

Skeem, Edens, Camp, and Colwell (2004) conducted a meta-analysis to resolve these discrepancies and found that there were differences in total score (.7 of a point) but that there were not differences in Factors 1 and 2 of the two-factor model of psychopathy. Skeem et al. (2004) concluded there was not sufficient evidence that African American's have higher core psychopathy traits than Caucasians. Although they believe that psychopathy can be measured reliably and in a valid manner in African Americans, Sullivan and Kosson (2006) disagree with Skeem et al. and suggest that future research should examine ethnic differences more closely. Furthermore, research should not only examine differences between African Americans and Caucasians but also other understudied ethnic groups.

In addition to ethnic differences, psychopathy also has been studied cross-culturally. Although the PCL-R has largely been used on offenders in Canada and the United States, there are a number of published studies in countries such as Scotland, England, Belgium, Norway, Spain, Portugal, the Netherlands, Germany, Argentina, and Sweden (see Sullivan & Kosson, 2006). Despite the widespread use of the PCL-R, examination of cross-cultural differences have been recent and data for Great Britain and Sweden only appeared in the most recent PCL-R manual (Hare, 2003). Furthermore, most of the research has focused on comparing European (even largely British) samples with North American samples. As a result, any conclusions that can be made about the cross-cultural application of psychopathy are tentative.

Nonetheless, there appears to be some important cross-cultural differences in psychopathy. Overall, the prevalence and mean scores appear to be higher in the North American samples. Sullivan and Kosson (2006) compared the mean score across offenders, psychiatric patients, and forensic patients for 19 samples outside of North America and compared their average score of 18.7 to an average score of 22.1 in the PCL-R manual. As a result of the differences between North American and Scottish samples, Cooke and Michie (1999) recommended using a cutoff score of 25 for psychopathy in Scotland, instead of 30. Other European psychologists have also adopted this modified cutoff score. Nonetheless, psychopathy appears to be a robust predictor of violent and general recidivism cross-culturally (Hare, Clark, Grann, & Thorton, 2000; Tengström, Grann, Långström, & Kullgren, 2000) and the cognitive and emotional deficits appear to be present across different countries (Pastors, Moltó, Vila, & Lang, 2003; Pham, Vanderstukken, Philippot, & Vanderlinden, 2003). Though there may be cross-cultural differences in psychopathy, it is equally clear that psychopathy remains a valid construct with application outside of North America (Sullivan & Kosson, 2006).

Children and Adolescents

In addition to examining the generalizability of psychopathy to a more diverse group of adult offenders, research also has focused on psychopathy in children and adolescents. The first major problem with extending psychopathy to children and adolescents is the same one that plagued the field prior to the 1980s—measurement. The most often used measure of psychopathy in adults, the PCL-R, is not applicable to youth. For example,

items like many short-term marital relationships and adult criminal versatility are not going to apply to juveniles. As a result, early studies focusing on youth used a modified version of the PCL-R that became known as the Psychopathy Checklist: Youth Version (PCL:YV). Several items on the PCL:YV were replaced and altered in order to be applicable to youth and specifically those 13 to 18 years of age (Forth, Kosson, & Hare, 2003). Two additional measures of psychopathy, the Antisocial Process Screening Device (ASPD) and the Childhood Psychopathy Scale (CPS), were designed to assess children as young as 6 years old (Salekin, 2006). Preliminary research has revealed that there is some support for the two-factor model originally found in adults but that there may be some slight differences in the items that load on the respective factors in youth (Forth, 1995; Frick, Bodin, & Barry, 2000).

As with adults, one of the initial areas of interest was violence and antisocial behavior. There are a number of studies examining psychopathy in youth and its relationship with antisocial behavior, with consistent results. Studies have found that youth who score high in psychopathy perpetrate more antisocial behavior (Corrado, Vincent, Hart, & Cohen, 2004) and they commit more severe violence (Gretton, Hare, & Catchpole, 2004). Results suggest that youths with psychopathic characteristics exhibit a similar relationship to violence and antisocial behavior as do adults. Lynam, Caspi, Moffitt, Loeber, and Stouthamer-Loeber (2007) conducted one of the first studies examining the long-term stability of psychopathy and found some evidence for the stability of psychopathy from adolescence to adulthood. Cauffman, Skeem, and Dmitrieva (in press) found similarly modest results and found that adolescents' PCL:YV scores dropped more than adult scores on the PCL-R over a two-year period.

However, there is much less consensus and evidence for the extension of some of the cognitive and emotional aspects of adult psychopathy within youth. Vitale et al. (2005) found expected differences in a Stroop-like task but only found evidence of passive avoidance learning in boys. Roussy and Toupin (2000) also found evidence of deficits in cognitive tasks designed to assess specific regions of the frontal lobe for which adult psychopaths have shown consistent characteristic performance patterns. In addition, other studies have supported the notion that children with psychopathic features have difficulty with automatic processing (O'Brien & Frick, 1996), an inclination for sensation seeking (Frick, O'Brien, Wooton, & McBurnett, 1994), and impulsivity deficits (Blair, 1999). In contrast to these studies focusing on disinhibition, more recent efforts have focused on affective aspects, specifically callous-unemotional features of the disorder (Frick & Moffitt, 2010).

Even if psychopathy is a valid construct for youth, there is a great deal of debate about the appropriateness of the psychopathy label in children. Much of the debate focuses on the fact that childhood and adolescence is a time of enormous developmental change and that for some youths this change includes acting out in an antisocial manner (Moffitt, 1993). As a result, it is very difficult to measure constructs like impulsivity and irresponsibility when these behaviors are likely to change and may even be encouraged in children (Edens, Skeem, Cruise, & Cauffman, 2001). Moreover, a label of psychopathy may have profound implications in the classroom or the legal system (Edens,

Guy, & Fernandez, 2003). Some have encouraged the use of other terms rather than psychopathy (Johnstone & Cooke, 2004). Others have suggested that the threshold for extending psychopathy to children should be higher than for adults, given the implications (Skeem et al., 2011). Clearly there are many reasons to be cautious with the application of psychopathy to children and adolescence, regardless of the sufficiency of the research.

Legal and Ethical Issues Involving Psychopathy

Psychopathy is used in a variety of legal contexts and Edens and Petrila (2006) even go so far as saying that psychopathy "is becoming pervasive in the law" as "it is increasingly being found in both judicial opinions and legislation, and it also has been the focus of expert testimony" (p. 573). Though an abstract notion of psychopathy has a legal history that dates back almost 100 years, it is only more recently that the term or a variation has been used explicitly (Reed, 1996). Lyon and Ogloff (2000) searched the appellate case law and found that psychopathy was discussed in a variety of cases including areas such as the death penalty, insanity, competency to stand trial, child custody, the credibility of witness, transfer of juveniles to adult courts, civil commitment, and civil torts. DeMatteo and Edens (2006), in a comprehensive review of the available U.S. case law, found that there have been recent sharp increases in the admission of the PCL-R. However, even though the term has become widely used in the legal system, the legal notion of psychopathy does not always match the clinical or the psychological notion. For example, the term *sexual psychopath* is being increasingly used in the law to mean someone who fails to maintain control over his sexual impulses (Mercado, Schopp, & Bornstein, 2005) but a lack of control is not the defining feature of psychopathy. Therefore, if a forensic psychologist uses the PCL-R while evaluating a sexual offender, the results may be useful clinically to determine whether the individual can be diagnosed as a psychopath. However, a score of 30 and above on the PCL-R does not mimic the legal definition of psychopathy and may be a reason for concern in offering this type of information to the courts (Edens & Petrila, 2006).

Capital Sentencing and the Use of Psychopathy

As with the other issues in this book, psychopathy has relevance for both scope of practice and the influence of the law. Although capital sentencing decisions do not represent the most prevalent types of evaluations in which psychopathy is used (DeMatteo & Edens, 2006), they do provide an excellent situation to examine both the impact of the law and the potential limits of expert testimony.

The United States Supreme Court has held that there must be limitations on eligibility to receive the death penalty in capital cases and that specific characteristics of the accused are relevant in that determination (Hesseltine, 1995). A forensic

psychologist is often called to testify in the sentencing phase of these trials, after the accused has been determined guilty, in order to determine the individual's risk for future violence. Though commentators have identified a host of problems with expert testimony in capital sentencing decisions (Cunningham & Reidy, 1999), there are also specific problems with employing psychopathy as a potential issue. A forensic psychologist called to testify in these instances will typically offer testimony as to the defendant's risk for future violence to assist the court in determining whether life in prison or the death penalty is the most appropriate sentence. If an individual is at significant risk for violence or even murder while serving life in prison, the court may determine that the death penalty is the most appropriate sentence to protect other inmates and correctional staff.

Experts have testified in these instances that the defendant poses substantial risk if sentenced to life in prison because he scores above the cutoff score of 30 on the PCL-R (Edens, 2001). Given the extensive literature supporting the notion that psychopathy is potentially the best predictor of future violence (Salekin et al. 1996), this conclusion does not initially seem problematic. However, the problem is that the literature examining the potential predictive effect of psychopathy for future violence has largely focused on community violence. The research has focused on the likelihood of psychopaths engaging in violence when left unsupervised in the community. This situation is not the same for a person who is sentenced to life in prison. Not only is such a person incarcerated but that person may be locked down 23 hours per day for the rest of his life. Nonetheless, one of the first studies examining the association between psychopathy and violence during incarceration found a significant correlation (Forth, Hart, & Hare, 1990). However, most reviews of the literature have concluded that there is a nonsignificant to modest relationship between any institutional misconduct and psychopathy. Cunningham and Reidy (1999) went further and concluded that there was virtually no empirical evidence supporting the use of the PCL-R in death penalty cases where the individual was not only institutionalized but locked down in a high-security prison. A recent meta-analysis by Guy, Edens, Anthony, and Douglas (2005) supported these reviews and found only a small correlation of .11 between psychopathy and physical violence.

As this evidence suggests, one could argue it is outside a forensic psychologist's scope of practice to testify that based on a diagnosis of psychopathy a convicted murderer should be sentenced to death. Several scholars have argued that the research does not support a claim for this link regarding institutional violence and that it is even more difficult to support such a link given the lower rates of institutional violence for offenders serving life sentences (e.g., Edens, Buffington-Vollum, Keilen, Roskamp, & Anthony, 2005). The research does not offer the forensic psychologist any expertise in making competent conclusions in these situations to date. However, others point out the significant relationship between psychopathy and almost every other form of violence and suggest that psychopathy is relevant to these determinations and maybe even necessary.

Additionally troubling may be that the profound impact that a label of psychopathy carries. Edens, Colwell, Desforges, and Fernandez (2005) found that when an expert testified that a defendant was psychopathic, a much greater percentage of jurors supported the death sentence. As a result, the legal system is faced not only with imposing

the most severe consequence possible, the death penalty, but in doing so based on expert testimony that is not generally supported by the literature. Although some may question the therapeutic nature of the death penalty in general, the current focus has nothing to do with the overall issue of the death penalty. The anti-therapeutic implications of admitting expert testimony that is not supported by research on any issue is clear. The implications become even more profound if different jurisdictions begin to specifically mention psychopathy as an aggravating factor in death penalty cases similar to statutes in Canada that have done so in regard to non-capital cases (Zinger & Forth, 1998).

Reflection and Review

1. How is psychopathy different than antisocial personality disorder? How is it the same?
2. Do experts believe criminal behavior is a central part of psychopathy?
3. What are the implications for the early findings regarding field research on the PCL-R?
4. Are psychopaths treatable?
5. Should children be diagnosed as psychopaths?

Key Terms

antisocial personality disorder
instrumental violence
passive avoidance learning
primary psychopathy
psychopathy
reactive violence
secondary psychopathy
sham emotions
successful psychopaths

Further Readings

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5 Violence Risk Assessment

Chapter Objectives

1. Identify the nature of violence and the purpose of risk assessment
2. Describe the historical development of risk assessment
3. Understand the differences among the various approaches to risk assessment and the role of risk management
4. Discuss some of the issues that impact the accuracy of risk assessments

As our discussion of psychopathy in Chapter 4 suggested, evaluating the violence potential of an individual is a prominent focus of forensic psychology and the law. When courts determine the sentence for an individual, they often rely on pre-sentence investigations that assess the likelihood of an individual committing another violent offense in the future. Dangerousness is a specific requirement for one legal process, civil commitment, which we will examine in Chapter 7. Parole and probation decisions or even the level of supervision required for someone released from incarceration are based on determinations of that individual's risk of violence. Before determinations are made whether to transfer a juvenile to an adult court or not, an evaluation of future violence tendencies is likely to occur (Chapter 11). Moreover, schools, businesses, and the government are increasingly assessing the potential for violence among students, employees, or people who threaten government officials. Over the past several decades there have been a number of important legal and psychological changes that have drastically advanced the field of **risk assessment**. Legally, the courts have made it clear they value, if not rely upon, violence risk assessment in making a host of legal determinations previously mentioned, despite the limitations of risk assessments. Empirically, the literature has made amazing progress from making a more concerted effort at identifying the relevant risk factors to devising structured and actuarial approaches to assess violence

risk. As a result, it has become even more important that forensic psychologists performing risk assessments are up to date on the literature and mindful of the limitations on their scope of practice.

Nature of Violence and Violence Risk Assessment

Defining Violence

Before beginning our discussion of violence risk assessment, it is important to examine our understanding of the term *violence*. There are a variety of acts that could be considered violent or aggressive. However, we will define violence in a way that will make it more amenable to the accurate assessment by forensic psychologists and useful to the legal system. Hart (2005) offers a very straightforward and concise definition of violence that includes "actual, attempted, or threatened physical harm that is deliberate and nonconsenting" (p. 4). This definition is useful in violence risk assessment for several reasons. It excludes consensual physical contact that would occur in sports like hockey or football and accidents such as backing over your friend's foot with your new Ford Festiva. This definition also focuses on physical harm, which is important because the manner in which violence is measured is central to risk assessment and a violent act resulting in physical harm is easier to measure.

As a result, this definition excludes potential forms of violence such as emotional or verbal violence. Although emotional violence can be extremely damaging to victims of domestic violence (Chapter 10), emotional violence tends to be less relevant in many legal situations. The legal system does not base a decision on whether someone should be released on bail or sentenced to a longer criminal sentence because they might yell at a fast-food worker for forgetting his special sauce on his cheeseburger. The legal system is more concerned with a potential perpetrator punching or assaulting the fast-food worker. Physical harm encompasses a wide variety of violent acts such as a bar fight, pushing and shoving, use of a weapon, or a sexual assault. Though the definition also includes attempted or threatened physical harm, these must be severe enough to warrant serious attention or legal sanctions. Brandishing a knife or attempting to fire a gun into a crowd, even though it fails to discharge because of a malfunction, would still be relevant for most risk assessments. An elderly lady shaking her finger and saying "I'm going to get you" at someone who cuts her off in traffic is not typically a violent event for the sake of risk assessment.

Violence as a Choice

Another important point to mention about our conceptualization of violence is that violence is a choice. "The proximate cause of violence is a decision to act violently" (Hart, 2005, p. 5). Many people struggle with the idea that violence is a choice. It makes sense that if someone gets out of her car because she has been cut off in traffic and uses a baseball bat on the offending driver's windshield, the behavior to act that way

was a choice. But, what if the baseball bat wielding driver had been drinking? Was the behavior still a choice? What if she was on drugs? What if someone slipped the drugs into her diet soda? Was it still a choice? Is it still a choice if a driver rams into your car on the passenger side where your young daughter is buckled into her seat and you get out confronting him with a baseball bat? What if he comes at you with a baseball bat first? Violent behavior does not occur automatically. There are countless reasons or antecedents for someone choosing to act violently, no matter the situation. The decision is influenced by a variety of psychological, societal, and biological factors but it remains a choice nonetheless.

The conceptualization that violence is a choice is important for many reasons. First, the legal system views the commission of violence as a choice. The police do not routinely arrest people, put them on trial, and incarcerate them for something that was accidental. *Mens rea* is a term we used previously and that suggests a belief that criminal behavior is volitional or that someone is responsible for his or her behavior. Mens rea means that someone has intentionally committed an act, violent or otherwise, with a guilty or wrongful purpose. However, there are instances in which mens rea is absent or diminished. For example, if someone is found insane, his legal responsibility for committing the act is voided (Chapter 9). However, as we will learn, insanity is very rare and simply having difficulty controlling your actions or even suffering from a mental illness is not sufficient to be found insane. Part of the definition for insanity often relies on the person not only having a mental illness but being unable to control his behavior or distinguish right from wrong; his illness is so severe that his behavior is no longer a choice. Second, the very nature of psychology is based on the fact that you can make predictions. Psychology is often described as the science of behavior and mental processes and like any science it attempts to describe in order to predict and alter behavior. Clinical psychologists study mental illnesses to find the cause, arrive at a common definition, and treat the illnesses. This process is all about predicting and any choice can be predicted (Hart, 2005).

Predicting violence is certainly not without controversy though. There are several potential arguments against predicting violence (see Hart, 2005). Violence tends to be rare. Even in the most violent and aggressive contexts violence may only occur 30% of the time. Some argue that because violence is so rare, we cannot predict it accurately. Others argue that clinical predictions of violence are inherently biased and therefore are especially poor (Quinsey, Harris, Rice, & Cormier, 2006). It has even been argued that psychologists or mental health professionals do not have any unique expertise to predict violence in comparison to the general public. Many people view psychology as deterministic and that psychologists believe we do not have a choice in our behavior. This notion harkens back to the view of people as rats or pigeons in a Skinner box waiting to be reinforced or punished for a behavior.

However, there also are opposing views that suggest we can predict violence (see Hart, 2005). The violence risk assessment literature is growing and increasingly identifying those instances in which forensic psychologists can predict violence accurately and reliably. Moreover, whether we can predict violence or not is unimportant. It is unimportant because we are not trying only to predict whether a behavior occurs or not;

rather, we are trying to assess and describe the risk. A good assessment of risk does not simply identify whether someone is going to be violent in the future. It also describes things like the potential severity of the violence and the context in which it occurs (Douglas & Ogloff, 2003). For example, it is not only important for a forensic psychologist to state that someone awaiting possible release from prison is or is not likely to be violent. That forensic psychologists should suggest the nature of the likely violence (physical assault of a stranger, domestic violence, sexual assault), its severity (murder, severe physical assault, use of a weapon), or the conditions under which it will occur (while drunk, after a divorce, in the commission of other crimes). A good risk assessment is a thorough description, not a simple prediction.

We will continue to talk about *scope of practice* and the importance of the law in forensic psychology. Because violence risk assessment has undergone tremendous change in the past several decades and continues to evolve, it is extremely important for forensic psychologists to keep themselves updated on the most current research to ensure they are staying within their scope of practice. For example, the ongoing debate between clinical and actuarial risk assessments is the focus of much discussion among forensic psychologists about the best way to assess risk. Risk assessment also is an area of forensic practice that is dramatically influenced by the law. Many of the improvements that have occurred in violence risk assessment are at least partially the result of the courts and the increasing need for risk assessments. Of course, these legal decisions have the potential to have a positive or negative effect on mental health either through the practicing forensic psychologist or directly on the people that clinician is assessing. Accurate methods of risk assessment are necessary to promote the well-being of society as a whole as well as that of a specific individual who may be facing a more severe sentence or a reduction in freedom.

Legal Realities of Violence Risk Assessments

Much like the *Jenkins* decision helped spur the development of forensic psychology as a whole, another United States Supreme Court case encouraged development in the field of violence risk assessment. Experts testified in *Barefoot v. Estelle* (1983) that the defendant, who had been convicted of murder, should receive the death penalty because of his ongoing risk to be violent. Partially on the basis of this testimony, the court handed down a sentence of death for Barefoot, despite the inaccuracies of conventional risk assessment at the time (*Barefoot v. Estelle*, 1983; Box 5.1). As a result, psychologists and psychiatrists are allowed to present testimony on someone's future risk of violence. Be sure to take note of the ability of mental health professionals to assess risk at the time of *Barefoot v. Estelle* (1983) when we discuss the different generational development of risk assessment.

The admissibility of risk assessment testimony was further extended by other Supreme Court decisions. In *Schall v. Martin* (1984), a lawsuit was brought on behalf of a group of juveniles in New York. Juveniles in New York were routinely held at the discretion of a judge at this time if it was deemed they would not return for their court date

Box 5.1. Experts Cannot Predict Violence, So What! *Barefoot v. Estelle* (1983)

The most important single case in the history of risk assessment involved Thomas Barefoot, largely because it surprised forensic psychology by encouraging the continued practice of violence risk assessments. Thomas Barefoot burned down a bar in Texas and then later shot the police officer investigating the arson. In 1978, he was convicted of murder and awaited sentencing. One of the questions before the court during the sentencing hearing was the probability of Barefoot being violent again and continuing to be a threat to society (*Barefoot v. Estelle*, 1983). During the sentencing hearing, one psychiatrist, Dr. James Grigson, testified there was 100% absolute certainty that Barefoot would commit future violence in prison, if he was not executed. Grigson further stated that Barefoot was above a 10 on a 1 to 10 point scale of sociopathy. In addition, this psychiatrist and another expert testified for the state without ever interviewing the defendant, a significant professional error (Cunningham & Goldstein, 2003; Litwack et al., 2006). Dr. Grigson was later expelled from the American Psychiatric Association (Cunningham & Goldstein, 2003) but did not lose his license and continued to practice psychiatry for decades.

On appeal, Barefoot challenged the testimony of the psychiatrists. The American Psychiatric Association filed an amicus curiae brief. An **amicus brief** is a legal document written by a person or entity that is not a party in a given case but that has an interest in the matter before the court. An amicus brief is used to inform the court of relevant considerations in which the interested party has some special expertise. The American Psychiatric Association questioned the validity of opinions on future dangerousness and pointed to literature that predictions of future dangerousness were unreliable, given they were inaccurate two out of every three times. The court agreed that this type of testimony was not always correct but believed that the adversarial process would be able to properly screen it and that juries would assign it the appropriate weight.

or they would commit a crime upon release. The Supreme Court again ruled these types of risk assessment decisions were appropriate, overruling the lower court that had held these decisions were too arbitrary and inaccurate. The Court specifically stated that, "from a legal point of view there is nothing inherently unattainable about a prediction of future criminal conduct" (p. 278). More recent cases concerned with the confinement of sex offenders for civil commitment have only solidified the use of expert testimony for predictions of future violence (*Kansas v. Crane*, 2002; *Kansas v. Hendricks*, 1997). Although they did not focus on the admissibility of expert testimony itself, there are additional legal decisions that required a finding of dangerousness that are equally important to the advancement of risk assessment. *O'Connor v. Donaldson* (1975) demanded that the criteria in civil commitment include dangerousness and by doing so led the courts to seek out expert opinions on future dangerousness. *Tarasoff v. Regents of the University of California* (1976) required practicing mental health professionals, not just forensic psychologists, to exhibit a duty to protect individuals at risk

Table 5.1. Important Legal Cases in the Development of Risk Assessment

Supreme Court case	Relevant aspects of the decision
O'Connor v. Donaldson (1975)	A person cannot be committed only on the basis of a mental illness but must also exhibit imminent dangerousness
Tarasoff v. Regents of the University of California (1976)	Required of mental health professionals a duty to warn that necessitates an evaluation of a patient's potential to become violent toward a specific person
Barefoot v. Estelle (1983)	Expert testimony on dangerousness may not always be correct but it is admissible and the adversarial process should properly evaluate it
Schall v. Martin (1984)	Preventative detention is allowable based on a prediction that the accused poses a serious risk of future criminal conduct
Kansas v. Hendricks (1997) and *Kansas v. Crane* (2002)	Affirmed the constitutionality of sexually violent predator statutes and the use of dangerousness determinations to commit them

for becoming victims of future violence and thereby they must assess for future risk outside of forensic situations (see Table 5.1 for a summary of these cases).

All of these cases support the notion that the law can have a profound impact on the practice of forensic psychology and thereby on the mental health of individuals that come into contact with the legal system. If forensic psychology had responded to these cases with a business-as-usual mentality, individual rights could be at stake along with the mental health of those individuals released because of poor violence risk assessments and those who were institutionalized. The best research available indicated that clinicians were more often wrong than right (Monahan, 1981) and that flipping a coin was more accurate than predictions of violence (Ennis & Litwack, 1974). However, instead of maintaining the status quo, forensic psychologists used these court decisions to improve the reliability and validity of predictions of dangerousness and the therapeutic results.

The Evolution of Risk Assessment

Court cases such as *Barefoot* and *Schall* came at an interesting time for forensic psychology. There was significant pessimism about the ability of forensic psychologists to predict future dangerousness. John Monahan's (1981) famous review of the research concluded that predictions of dangerousness were wrong two out of three times. As a result, there was some surprise when the Supreme Court discounted the state of the scientific literature and continued to encourage this type of expert testimony. Although these court cases certainly were not the only impetus for the continued development of research in predictions of violence (Grisso, 1995), they did provide further encouragement for the heightened interest in the area that occurred in the late 1970s and into the 1980s.

Early History of Risk Assessment

Research on predictions of dangerousness and violence risk assessments have frequently been commented upon in terms of a generational development (e.g., Otto, 1992). The *first generation* of research that occurred during the 1970s largely focused on institutionalized individuals in psychiatric, forensic, and correctional settings awaiting release. The results of this first generation of research, especially the studies comparing mental health professionals' predictions against the outcomes in the community, were so poor that some called for the abolishment of civil commitment (see Monahan, 1981). Monahan (1988) articulated that there were four major shortcomings of this first generation of research. The studies focused on poor predictors of violence, enabled poorly measured and defined violence outcomes, used narrow samples, and were poorly organized (Monahan, 1988). Monahan (1988) further recommended a host of improvements to remedy the problems apparent in this research on violence risk assessment.

Although there is some disagreement about the strides made in the *second generation* of risk assessment research (see Steadman, 1992, for a contrary stance), most believed the field made tremendous advances by focusing on short-term predictions and identifying useful predictor variables that were more definitively associated with violence across domains (Otto, 1992; Poythress, 1992). Many studies during the second generation of research focused on short-term predictions, primarily in hospital settings (e.g., McNeil & Binder, 1987, 1991). These foci are in keeping with Monahan's (1988) suggestions, as these situations may allow for greater attention to precise data collection and control that would increase the accuracy of forensic psychologists.

Another improvement that set the foundation for the potential *third generation* of risk assessment research was the identification of individual and contextual variables that related to violence. Klassen and O'Connor (1988a, 1988b) conducted some of the most noted research among psychiatric samples. Klassen and O'Connor followed formerly hospitalized patients for upward of one year post discharge in the community. They identified patients who exhibited violence either via an arrest or re-admission to the hospital and those who were nonviolent. They then identified variables that related to prediction of one of these two groups and were able to classify 88% to 93% of the patients accurately, though the accuracy decreased when the model was applied to additional samples (Klassen & O'Connor, 1990).

In his review of this second generation of studies, Otto (1992) was cautiously optimistic. He stated that several improvements had been advanced during the last decade such as identifying various outcome or criterion measures beyond arrest records, a moderate base rate of violence for the mentally ill with a previous history of violence, and that mental health professionals have some ability to predict dangerousness. In regard to the third and final conclusion, Otto (1992) stated that "rather than only one in three predictions of long-term dangerousness being accurate, at least one in two short-term predictions of dangerousness behavior are accurate" (p. 130).

A final and very important development was the move from predicting dangerousness to assessing risk of violence (Poythress, 1992). Forensic psychologists historically referred to the process described here as predicting dangerousness, potentially because

of the legal tradition involved. However, the second generation encouraged the use of the phrase, *risk of violence*, for several reasons. Monahan (1992) believed the use of the word *dangerousness* encouraged dichotomous judgments (the person is dangerous or the person is not dangerous) that were in keeping with the dichotomous legal thinking but contrary to the probability of violence (e.g., a 20% probability of future violence) associated with assessing risk from a psychological standpoint. Dichotomous decisions also force potential variables of interest into a single conclusion that ignores the independence of the different factors (Poythress, 1992). We examine risk in different ways to avoid this problem. Also, by focusing on risk of violence, forensic psychologists can clearly identify the variables that present a risk (substance abuse, threats of aggression, violent fantasies) and the variable of interest, the violence (Poythress, 1992).

Assessing risk is not simply a matter of identifying whether someone is going to commit a violent act; there are multiple facets involved in risk assessment (Douglas & Ogloff, 2003). Instead of thinking about risk assessment as only the likelihood of someone becoming violent, it should be viewed as consisting of several different components (Hart, 2005). Hart has suggested there are five different facets to violence risk assessments that include (1) nature, (2) severity, (3) frequency, (4) imminence, and (5) likelihood. Although many measures designed for risk assessment only take into account likelihood of future violence occurring, it is equally important to consider the other four facets. What is the nature of the potential violence? The forensic psychologist should focus on different predictor variables and potentially have a different outcome if the focus is sexual violence, domestic violence, or general violence. What is the potential severity of the violence? The final decision will be much different if the potential severity is murder compared to a slap on the face. How frequently will the potential violence occur? Someone who is likely to commit repeated violent acts warrants more consideration than someone who is likely to commit a single act of equally severe violence. Finally, what is the imminence of the potential violence? This facet may be especially sensitive to intervention and treatment. If the imminence of the violence is immediate because of unmanaged symptoms of schizophrenia, then the imminence of violence will decrease once the individual is medicated. As a result, modern conceptualizations of risk assessment do not merely focus on the likelihood of the violence but also focus on additional factors that are equally important.

Clinical, Actuarial, and Structured Risk Assessments

A parallel development to the generational improvements in risk assessment has been the use of clinical judgment along with actuarial and structured methods. Clinical judgment is the traditional approach to violence risk assessment. **Clinical risk assessments** are based on human judgment, judgment that is shaped by education and professional experience. In contrast, instead of relying on human judgment, **actuarial risk assessment instruments** (ARAI) use "previously demonstrated associations between measurable and specified predictors and outcome variables and are ultimately determined

by fixed, or mechanical, and explicit rules" (Litwack, Zapf, Groscup, & Hart, 2006, p. 495). Finally, structured professional judgment approaches to risk assessment are a seeming middle ground to purely clinical and actuarial approaches. Structured approaches typically employ a standard framework or tool that identifies a list of factors relevant in arriving at an assessment of risk but the approach allows for clinical judgment while still being formal. The so-called *third generation* of risk assessment research has been marked by the actuarial and structured approaches that were developed in the 1990s. There has been a great deal of debate about the true nature of each of these different approaches and certainly the superiority of one over the other.

Clinical Assessments of Violence

Even though clinical assessments of violence have been the norm in forensic psychology, clinical judgment has often been disparaged as informal and subjective. Assigning grades based on my impressions of students' abilities in my class without identifying the specific points I wanted addressed on an exam would constitute purely clinical judgment. However, it is judgment that has been based on years of schooling, my knowledge of the research on teaching, and teaching students in a variety of different classes and of different abilities. Furthermore, clinical judgment is the basis for much of clinical psychology as we diagnose mental illness and seek to treat it. A clinical psychologist does not perform a complex statistical computation before she makes a suggestion in therapy or answers a client's question; she uses the skill she has acquired through education and experience. However, there is a long history in psychology of demonstrating the general superiority of actuarial decisions, decisions that tend to be fixed and based on a mathematical process, over pure clinical judgments (Meehl, 1954). As a result, clinical approaches to risk assessment have been questioned.

Early research on the accuracy of clinical judgment was even the basis for much of the pessimism regarding forensic psychology's inability to assess risk accurately (Monahan, 2003). Studies by early pioneers that suggested that forensic psychologists could clinically predict only 20% to 35% of patients accurately were all that existed over 30 years ago (Cocozza & Steadman, 1974; Kozol, Boucher, & Garofalo, 1972). However, additional studies offered some hope for clinical predictions. A study by Lidz, Mulvey, and Gardner (1993) was heralded as "the most sophisticated study published for the clinical prediction of violence" (Monahan, 1996, p. 111) and found that clinicians could predict violence at greater than chance (50%) levels. In fact, Mossman's (1994) meta-analysis of the available research on clinical predictions of violence clearly supported the notion that clinical predictions were more accurate than chance, or simply flipping a coin, and that long-term predictions (more than one year) may be no less accurate than short-term predictions (one to seven days). Furthermore, the evidence clearly showed that more recent studies suggested greater accuracy than previous studies, which were victim to many of the flaws Monahan previously identified. Other studies have shown clinical predictions could be accurate in certain situations such as when decisions were aggregated (Huss & Zeiss, 2004). Decisions are also more accurate when comparing master's level students making actuarial decisions and to psychiatrists and psychologists

making clinical decisions (Smee & Bowers, 2008). It can also be argued that there are clinical instances in which alternative approaches are not possible or certainly not available to forensic psychologists and that clinical judgment will always be necessary.

Actuarial Measures of Violence

As the field of risk assessment advanced, the third generation of research was marked by the advent of actuarial approaches to risk assessment. Actuarial approaches contrast with clinical approaches in that they tend to be more formal, algorithmic, and objective, and have a statistical basis. The second generation of risk assessment focused on identification of potential risk factors and served as a basis for the later development of actuarial and structured approaches to risk assessment. Though people such as Klassen and O'Connor (1988a, 1988b) attempted to use actuarial approaches earlier, Harris, Rice and Quinsey (1993) reported "a major advance in the development of actuarial risk assessment" (Monahan, 1996, p. 113) with their development of the first widely examined actuarial tool, the Violence Risk Assessment Guide (VRAG).

In several studies (Harris et al., 1993; Harris, Rice, & Cormier, 2002; Rice & Harris, 1995, 1997), groups of researchers examined the utility of the VRAG among forensic patients in Penetanguishene, Ontario. In their initial study, Harris et al. (1993) examined a sample of 618 men from a maximum security therapeutic community. These men were mentally disordered offenders who had been charged with serious crimes. Of the 618 total subjects, 332 were treated at a maximum security psychiatric hospital and 286 were only admitted for brief psychiatric assessments. Institutional files were coded for a host of variables and through a series of statistical procedures the variables that best predicted violence outcome over a 7-year average were chosen.

The VRAG consists of 12 items that are weighted according to the original statistical findings and include total score on the PCL-R, elementary school maladjustment, separation from either parent before age 16, a summary score for nonviolent criminal offenses prior to the current offense, marital status at the time of the current offense, age at the time of the current offense, previous failures on conditional release such as probation or parole, the severity of the victim injury during the current offense, whether the patient met criteria for schizophrenia, whether the patient met the criteria for a personality disorder, whether a female victim suffered the current offense, and alcohol abuse history score. These 12 weighted items are totaled to arrive at an overall score on the VRAG that can then be used to determine which of several categories a person should be placed within. Each of these categories has an accompanying level of risk for violence that suggests the risk a person poses over 7 and 10 years. A person with a score of −1 on the VRAG may correspond to a category with a 17% to 31% chance of being violent in the next 7 years. Studies using the VRAG have fairly consistently indicated that it can accurately classify around 70% to 75% of offenders (Quinsey et al., 2006).

Another significant actuarial approach was based on the MacArthur Risk Assessment Study (Monahan et al., 2001). The MacArthur Risk Assessment Study was a large multisite study that assessed both male and female acute civil psychiatric patients. The MacArthur group examined a large number of variables and followed patients, assessing

potential violence at 20 weeks and 1 year post discharge. However, the MacArthur group used a different approach to combining these variables than the VRAG and other actuarial instruments. The MacArthur group developed something called an Iterative Classification Tree (ICT). "A classification tree approach to violence risk assessment is predicted on an interactive and contingent model of violence, one that allows many different combinations of risk factors to classify a person as high or low risk" (Monahan, 2002, p. 69). As Monahan's description suggests, this is a complicated approach that is not as readily scored as most actuarial instruments. Because of the complex statistical approach, specific computer software, the Classification of Violence Risk (COVR), must be used to place patients in one of the two classification groups (high and low risk). Studies of this approach have been supportive of its use. In one study, Monahan et al. (2005) found that violence rates were 9% in the low-risk group and 35% for the high-risk group with a strict definition of violence and 9% and 49% with a broader definition of violence.

As a result of the success of ARAI and the potential biases and limitations of clinical judgments, many experts have expressed great confidence in actuarial approaches. Additional actuarial measures have even been developed that focus on domestic violence (e.g., Ontario Domestic Assault Risk Assessment) and sexual violence (e.g., Minnesota Sex Offender Screening Tool–Revised and Static-99). Reviews of the literature suggest that actuarial tools have passed several legal challenges and are routinely admissible in a variety of legal situations (Mossman, 2012). Quinsey et al. (2006) have gone so far as to suggest that actuarial tools should be the sole basis for assessments of violence risk. It is not simply a matter of supplementing clinical judgment with actuarial information but rather suggesting that actuarial approaches should completely replace clinical judgment and clinical judgment should be abandoned (Quinsey et al., 2006).

However, there remain a number of criticisms of ARAI. First, there are several reviews of the literature that suggest the evidence is lacking to conclude that actuarial approaches to risk assessment are clearly superior to clinical approaches (Litwack, 2001; Litwack et al., 2006) and that they encourage forensic psychologists to pay more attention to the available evidence before jumping to conclusions. Actuarial measures are often criticized for their lack of generalizability outside the original sample used to construct them. The COVR was originally only tested on three different acute psychiatric samples. It has not been tested on criminal offenders and was only tested on chronic psychiatric patients or even people outside the United States recently (Sturup, Kristiansson, & Lindqvist, 2011). The issue of generalizability can even impact single items. One of the items on the VRAG is whether the person has been diagnosed with schizophrenia. A person's score is lowered if he or she could be diagnosed with schizophrenia. However, the bulk of the risk assessment literature suggests that a diagnosis of a major mental illness increases risk (e.g., Douglas, Guy, & Hart, 2009; Van Dorn, Volavka, & Johnson, 2012). Given the nature of the VRAG construction sample and that individuals suffering from schizophrenia were stable and in treatment, it may be that these individuals were more likely to receive supervision post discharge and thereby less likely to be violent. Again, findings from the original sample may not be true anywhere else. Actuarial instruments need to be widely tested if we are to rely only on actuarial measures.

Another argument goes to the nomothetic nature of actuarial approaches versus the idiographic nature of risk assessment. **Nomothetic** normally refers to the study of cohorts or groups of people. **Idiographic** refers to the study of individuals. Actuarial measures rely on a nomothetic approach that applies group data to individual decisions. Since Person X scores an 86 on an instrument, a forensic psychologists may state that he has a 70% chance of being violent since of the 100 people who scored an 86 on the instrument in the original construction sample, 70 of them became violent (70%). The problem is that a forensic psychologist is not evaluating 100 people and he or she does not know if the individual client is one of the 70 or one of the 30 (Hart, Michie, & Cooke, 2007). One of the more notorious offenders in Canadian history, Paul Bernardo (see Figure 5.1), is a good illustration of this problem (Box 5.2). Offenders' premiums for car insurance provide a useful example of the idiographic versus nomothetic debate. Car insurance rates are assigned based on actuarial formulas. One of the variables that factors into the actuarial formulas is gender. Do the male students in class believe it is fair they are assigned a higher level of risk for accidents because of their gender? Although some men in class may have better driving records than some of the women in class, women generally are less likely to get into accidents and receive lower car insurance rates than men because of the actuarial predictions made by insurance companies.

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Figure 5.1. Paul Bernardo and his wife, Karla Holmolka, are two of the most notorious serial killers in the history of Canada. His scores on the VRAG are a good illustration of a potential problem with the strict actuarial approach to risk assessment. They are also the subject of Box 5.2 in this chapter.

Box 5.2. One of Canada's Most Notorious Serial Killers

Paul Bernardo was instantly one of Canada's most famous serial killers and rapists when his heinous crimes came to light in the 1990s. Bernardo and his wife, Karla Holmolka, were accused of killing at least three women and raping at least 75 others. One of those women, Holmolka's sister, was killed by overdosing her on a veterinary drug they used to sedate her during the rape. Despite his history of savage rape and murder, Bernardo scores very low on at least one actuarial risk measure, the VRAG. A forensic psychologist scoring Mr. Bernardo on the VRAG likely would arrive at a score of −1, which relates to a 17% to 31% probability of violence. The highest probably of violence in that range is barely above the 26% level, which Monahan and Silver (2003) identified as the threshold for which judges would identify someone as sufficiently dangerous so that they would not release them. Bernardo fails to score high on the instrument because he lived with his parents through adolescence, was free of any elementary school maladjustment, did not have a history of nonviolent or violent criminal offenses prior to his murder and rape trial, was married, had no previous probation or parole, and scored low on other items. Bernardo is an example of an individual whom most would consider extremely high risk to reoffend but whose score on an actuarial instrument does not match this belief.

Ms. Holmolka was originally thought to be an unwilling accomplice and a victim of Bernardo's sadistic abuse. However, after she agreed to a plea bargain in exchange for her testimony against Bernardo, police found evidence that suggested she was a more willing and active participant than originally thought. Videotape evidence showed that she raped many of the victims herself, other evidence suggests she also may have physically brutalized them, she reportedly studied about battered woman syndrome prior to her trial, and she received media attention for throwing parties with her lesbian lover while in prison. Many experts have suggested that she is an outstanding example of a female psychopath. Despite this evidence and behavior, Holmolka served her complete 12-year sentence and was released in 2005. She has never expressed remorse for her role publicly, was romantically involved with another murderer upon her release, is now married, has given birth to a boy, and is living in Quebec.

Another problem with strict actuarial decisions arises when those rare exceptions occur. What if an individual scores extremely low on an actuarial instrument but explicitly states during his exit interview that he will kill someone if he is released? The individual person (idiographic) is not going to follow the group outcome data (nomothetic). Actuarial instruments cannot account for all these possibilities but if the legal system and forensic psychology solely relied upon them, society would be faced with these types of decisions based only on actuarial scores and no clinical judgment.

Furthermore, actuarial approaches are only focused on prediction and don't consider management or treatment issues (Jackson & Guyton, 2008). We will discuss management in more detail later in this chapter but for now understand that actuarial decisions do not allow us to try to reduce the overall violence and continually monitor it. They do not give us a context for potential future violence nor are they malleable to the changing factors present in the life of a real person assessed using one of these measures.

Table 5.2. Items from the HCR-20

Historical items	Previous violence
	Young age at first violent incident
	Relationship instability
	Employment problems
	Substance use problems
	Major mental illness
	Psychopathy
	Early maladjustment
	Personality disorder
	Prior supervision failure
Clinical items	Lack of insight
	Negative attitudes
	Active symptoms of major mental illness
	Impulsivity
	Unresponsive to treatment
Risk items	Plans lack feasibility
	Exposure to destabilizers
	Lack of personal support
	Noncompliance with remediation attempts
	Stress

Source: Adapted from Webster, Douglas, Eaves, & Hart (1997)

Structured Professional Judgments

An approach that clearly emerged by the late 1990s was the use of structured risk assessment approaches or **structured professional judgment** (SPJ). SPJ focuses on lists of important risk factors and general guidelines for using those risk factors. Structured approaches to risk assessment are normally based on identification of a list of factors from the relevant scientific literature (Litwack et al., 2006). Structured approaches such as the Historical, Clinical, Risk Management-20 (HCR-20) can be scored similar to an actuarial measure. For example, the HCR-20 is comprised of 20 items focusing on historical, clinical, and risk areas. Each item is scored similar to the PCL-R. If there is no evidence of the presence of an item, it is scored a zero. If there is definitive evidence of a particular item, it is scored a two. A score of one is given if there is some but less than definitive evidence for the presence of a particular item. A list of the HCR-20 items is located in Table 5.2. The difference between a measure like the HCR-20 and an actuarial measure like the COVR is that clinical judgment is encouraged and is necessary in arriving at a final decision for the HCR-20. One does not arrive at a total score using SPJ that translates into a probability of future violence, though numeric scores are used to evaluate their reliability and validity for research purposes. The technique encourages a structured approach that allows for a better informed final decision than a strictly clinical approach. As a result, an individual like

Paul Bernardo may score low on the HCR-20 but the fact that he has killed at least three times and is known to have sexually assaulted 75 women would allow the forensic psychologist to place him at high risk for future violence. In essence, a forensic psychologist can override a final score on an instrument. However, this practice also increases the chance of bias that actuarial approaches avoid.

The evidence concerning the use of SPJ is promising. The HCR-20 was originally validated on a sample of civil psychiatric patients but also has been validated on correctional samples (Douglas & Webster, 1999) both inside and outside of North America (Grann, Belfrage, & Tengstrom, 2000). Studies show that the HCR-20 is equal if not superior to actuarial measures in predictive ability (Douglas, Yeomans, & Boer, 2005; Doyle, Dolan, & McGovern, 2002; Grann et al., 2000). There also are structured approaches for assessing domestic violence (Spousal Assault Risk Assessment; SARA) and sexual violence (Sexual Violence Risk-20; SVR-20). Though the evidence is less abundant than for the HCR-20, there is also support for the use of the SARA (Kropp & Hart, 2000) and the SVR-20 (de Vogel, de Ruiter, van Beek, & Mead, 2004).

At this time, there is no clear consensus among forensic psychologists as to the best approach for conducting a violence risk assessment. Professionals such as the group in Penetanguishene, Ontario, argue for the abandonment of any clinical or structured approaches and a strict use of actuarial measures (Quinsey et al., 2006). Furthermore, they freely admit that their opinion has changed over the years as they have evaluated the developing research (Quinsey, Harris, Rice, & Cormier, 1998). Others argue for a combined actuarial and clinical approach (Hanson & Harris, 2000). The issue becomes even more complicated as others argue that it is difficult, if not impossible, to separate clinical and actuarial approaches because good clinical practice includes the use of actuarial approaches, though it allows for deviation from the results (Litwack, 2001). The conflict is even more complicated because of the continued limitations of the current research, some of which are inherent to risk assessment. Even an extensive meta-analysis has not settled the question. Yang, Wong, and Coid (2010) found that neither actuarial nor SJP were superior to one another and were basically interchangeable. One reason for these results may have been identified by Kroner, Mills, and Reddon (2005) in their coffee can approach to risk assessment (see Box 5.3). At this point, Skeem and Monahan (2011) argue the field has probably maximized its ability to assess violence by devising specific instruments and would be better served by trying to understand the causes and preventing reoccurrence of violence.

Risk and Protective Factors

So far we have talked about some of the general issues relevant to violence risk assessment. However, we have not discussed some of the specific factors relevant to an assessment of future risk. Generally, risk factors for violence can be divided into static risk factors and dynamic risk factors. Static factors are normally fixed and unchanged across time. Dynamic factors tend to be malleable and altered by time or specific forces. One of the previously discussed risk assessment measures, the HCR-20,

Box 5.3. Focus on Research: What Is the Coffee Can Approach?

Kroner et al. (2005) took a novel approach to risk assessment research but one with important implications to forensic psychologists. They took individual items from the PCL-R, VRAG, LSI-R, and another risk assessment instrument, wrote them on pieces of cardstock, placed them in a literal coffee can, shook up the coffee can, and selected individual cards out one at a time to create four new tools of risk. They then compared the four new coffee can instruments to the other four well-validated risk instruments. They found that the four new coffee can instruments predicted as well as the original instruments. The results suggested that all risk assessment instruments tap certain common factors among them and that these factors account for their predictive ability, not something unique about any of the instruments. The authors concluded that the results argue for a construct-based approach to risk assessment instead of one that simply taps into some aspect of criminality. This approach is also likely to lead to management and intervention strategies to reduce violence.

One could argue that these results suggest that there is nothing really unique to any of the risk assessment instruments. If you have seen one, you have in essence seen them all. However, it does not rule out the importance of continuing to use only particular instruments that have been validated on a sample similar to the one you wish to use it one. Furthermore, it encourages us to look at risk not so much in terms of predicting future violence but in intervening and trying to reduce it. This conclusion appears to be very much in keeping with Skeem and Monahan's (2011) argument that we may have maximized our ability to devise a better measure of risk and should turn towards preventing violent recidivism.

will serve as a good exemplar for the differences between these two types of risk factors. In addition to risk factors, the importance of protective factors or factors that reduce the risk of violence has been recently examined.

Static Risk Factors

Historical or **static factors** are variables that increase the risk of future violence but are unlikely to change and are often fixed. For example, gender and ethnicity are two clearly static factors. A person's gender or ethnicity typically does not change over the course of a lifetime. Most static factors are a little less concrete in terms of their fixed nature. Previous history of violence is generally considered a static risk factor. If an offender or patient has been violent before, that aspect is not going to change. They cannot erase the violent behavior or the legal conviction that may have resulted from it. Of course, if someone has never been violent, that can change if she becomes violent. The entire historical scale of the HCR-20 is comprised of variables that are generally considered to be static. Positive indications of factors like the age at which someone's first violent behavior occurred, history of relationship or employment instability, previous substance abuse, a diagnosis of a mental disorder, psychopathy, early maladjustment, a diagnosis of a personality disorder, or failing during a prior supervision are fixed.

Static factors were some of the first risk factors identified by forensic psychologists as risk factors for future violence and constitute the majority of the risk assessment research (Gardner, Lidz, Mulvey, & Shaw, 1996a). Generally, static factors are more easily identifiable during routine forensic assessments and more objectively defined. Furthermore, static risk factors are most useful in long-term assessments of risk (Hanson & Morton-Bourgon, 2005). However, focusing only on static factors is problematic when assessing risk because, like the factors themselves, it treats risk as a fixed entity that does not change over time. Only focusing on static factors suggests that once an individual's risk has been determined, it is never going to change. This view is in conflict with the idea that criminal offenders can be rehabilitated and that psychiatric patients can be successfully treated. More importantly, we know that individual risk does change over time because of individual factors and contextual reasons (Douglas & Skeem, 2005). Nonetheless, most risk assessment measures focus almost exclusively on static variables.

Dynamic Risk Factors

Traditional risk assessment measures that focus on static factors are missing a significant consideration when examining a person's risk—dynamic factors. In contrast to static factors, **dynamic factors** tend to be malleable and responsive to change or intervention. Only more recently have forensic psychologists begun to give consideration to dynamic factors and truly integrate them into their risk assessments (Doren, 2004). The items on the clinical scale (lack of insight, negative attitudes, psychiatric symptoms, behavioral and affective instability, and unresponsiveness to treatment) and the risk scale (plans lack feasibility, exposure to destabilizers, lack of social support, noncompliance with medication, and stress) of the HCR-20 provide a list of potential dynamic factors that should be considered in violence risk assessments.

Dynamic risk factors tend to be more difficult to identify and study. However, the job of forensic psychologists is evolving from simply estimating risk one time to ongoing management. As a result of their openness to change, dynamic variables are increasingly targeted in interventions to manage and reduce violence. Unfortunately, there is not a great deal of research assessing our ability to measure these dynamic variables or whether changing them is even possible. Two different measures, the Violence Risk Scale (VRS) and the Short-Term Assessment of Risk Treatability (START), have shown some promise. The VRS is based on something called the Stages of Change model (Prochaska, DiClemente, & Norcross, 1992) and is designed to assess the level of change that has taken place in risk after treatment. The START is an SPJ guide intended to measure 20 dynamic variables in order to make decisions on the level of care for individuals at risk for violence. Although published evidence has supported the ability of both measures to predict future violence (Desmarais, Nicholls, Wilson, & Brink, 2012; Wong & Olver, 2010), support for their ability to measure change in dynamic variables and be fully useful in risk management is still needed. As the mental health system becomes more community-based and patients are moved out of institutions, the necessity for interventions to reduce risk or identify the dynamic risk factors associated with

risk are even more important (see Douglas & Skeem, 2005). It also tends to be a small percentage of the most seriously disturbed individuals who are committing repeated acts of violence (Gardner, Lidz, Mulvey, & Shaw, 1996b). As a result, the distinction between risk assessment focused on prediction and risk management is important.

Risk assessment and risk management

Another step in the evolution of dangerousness predictions that is dependent on the identification of dynamic risk factors is **risk management** (Monahan & Steadman, 1994). As the focus of risk assessment has shifted from single administrations, suggestive of an ongoing fixed level of risk, to recognition of the need for multiple administrations and risk reduction, the idea of risk management has become important (Heilbrun, 1997). For example, while working on a civil psychiatric unit, I once had a patient who was arrested for a physical confrontation with another homeless man. He arrived at the hospital with active symptoms of schizophrenia and claimed to be a descendant of Pocahontas. Over the course of several weeks and months, his symptoms continually improved and he became more stable. There were several points throughout his treatment that staff were required by law to make a decision regarding his risk and whether he should be released. If we had simply assessed his risk immediately after the assault when his symptoms were active and never changed our evaluation of his potential risk, he would never have been a good candidate for discharge. As his symptoms decreased and he received treatment for a co-occurring substance abuse problem, he became a much better candidate for discharge, was eventually released, and did not return to the hospital.

Heilbrun (1997) identified several differences between a prediction-oriented model of risk assessment and risk management. First, the central *goal* of risk assessment is to identify whether an individual is likely to become violent at some point in time. The goal of risk management is to reduce the likelihood of aggression. Second, the *nature of the risk factors* in risk assessment is going to be both static and dynamic, but in risk management the focus is going to be primarily on dynamic variables that can change in order to reduce violence. Third, the *nature of post assessment control* is also different. In risk assessment, there often is not the ability to supervise individuals continually. Once they are released, they are on their own. In risk management, there must be some ability to monitor and follow people continually in order to assess their progress. Fourth, as our previous discussion already suggests, there is a difference in *the number of administrations*. Risk management necessitates multiple administrations of a violence risk assessment whereas prediction-focused risk assessment assumes a single administration. The implication for risk assessments are not that the manner in which risk assessments are conducted should inherently change. Risk management is merely an additional reminder that risk assessment is multifaceted both in terms of the prediction and in terms of the process.

A risk management approach definitely encourages intervention or treatment instead of a simple traditional assessment. The process is a nice example of the interaction of assessment and treatment. A common part of the violence risk assessment is to make treatment recommendations. You might also remember that risk assessments don't

simply assess the likelihood of risk but also identify the factors that are relevant and the context of the violence. As was mentioned previously, Hart (2005) suggested five different facets to violence risk assessments: (1) nature, (2) severity, (3) frequency, (4) imminence, and (5) likelihood. A risk assessment should not simply address these aspects but also relate them to a potential intervention or ongoing management strategy. The strategy should be designed to minimize the risk for future violence in terms of not only likelihood, but severity, frequency, and so forth. Although the legal system may find simple predictions worthwhile, the true value of forensic psychology comes in reducing the chances of reoccurring violence through managing it.

Protective Factors

A final aspect of risk assessment that has been sorely overlooked is the use of protective factors (Rogers, 2000). Most models of risk assessment focus on the factors that are likely to exclusively increase risk without paying attention to the factors that are likely to decrease risk. **Protective factors** are factors that decrease the likelihood of someone committing violence. The suicide prevention literature does a better job at identifying protective factors in assessing suicide risk than the risk assessment literature for violence toward others (Montross, Zisook, & Kasckow, 2005). For example, a person may present significant risk for suicide because of a history of depression, current symptoms of depression, substance abuse problems, and the recent death of a spouse. However, if that same person presents with a very wide and supportive social network of friends and family and has strong religious convictions that strongly discourage suicide, they act as buffers to reduce his likelihood of suicide. The literature on violence toward others is significantly lacking in terms of not only the identification of protective factors but the incorporation of those factors into models of risk assessment. Although the adolescent literature has identified and supported the use of protective factors in violence risk assessment (Gilgun, Klein, & Pranis, 2000), the adult literature has been sorely lacking in this regard. However, models for the assessment of risk incorporate so-called protective factors (see Doren, 2004; Desmarais et al., 2012). Furthermore, Ullrich and Coid (2011) did identify potential protective factors for adults from a review of the available literature. Their list included perceived social support; perceived emotional support; spending spare time with friends/family; belonging to a group, club, or organization; involvement in religious activities; closeness to others; relationship competence; proactive behaviors/initiative; having a place to stay after release; private accommodation; stability of address; having an income; being able to financially manage a household well; being in work, training, or education; and having had any job since release.

The definition or conceptualization of protective factors is not always clear. Protective factors are normally factors that interact with risk factors to reduce someone's risk for violence (Rogers, 2000). They offer an explanation for why two people with identical levels of risk may behave differently. Just as risk factors do not guarantee that an individual is going to become violent, protective factors do not guarantee

that someone is going to continue being nonviolent. Moreover, protective factors are not simply the absence of risk factors but they reduce, not just fail to increase, the level of risk. That does not mean the absence of a risk factor cannot be a protective factor, just that the absence is not automatically a protective factor. For example, psychopathy is clearly a risk factor for incarcerated criminal offenders in assessing their risk to commit additional violence upon release. However, does the absence of psychopathy reduce one's risk significantly compared to the average offender? The research is largely quiet on that question but we cannot assume that it does simply because of its absence (Rogers, 2000). If you were thinking about going to some warm tropical location for a vacation, would you only think about the reasons not to go (sunburn, spending money, potential hassle of travel)? Or would you consider all the benefits and good things that would come out of it? Considering only the risk factors in making risk assessments is very similar. A forensic psychologist should consider both the risk factors and the protective factors.

Accuracy of Risk Assessment

People often ask how accurate we are at assessing risk. That question is very difficult to answer with a single percentage or phrase. Although AUC (Area Under the Curve) estimates, the standard metric for violence research, typically range from .65–.71 (Yang et al., 2010), it is still not a simple question. Rather than being able to definitively state the accuracy of forensic psychologists at assessing the risk of violence, it is probably better to identify some of the difficult aspects of violence to assess and some of the situations in which forensic psychologists are good at assessing risk.

Difficulties in Risk Assessment

There are a number of problems that are associated with studying and assessing violence risk. Some of these problems are inherent to assessing violence, whereas others continue to be problematic despite Monahan's (1984, 1988) earlier critiques. Several of the difficulties with assessing risk are because of the nature of violence itself. Specifically, it is difficult to obtain accurate follow-up information. Violence is a behavior that is not readily reported or easily identifiable except in extreme cases. Moreover, collection of follow-up data necessitates following individuals who tend to be more transient and less likely to maintain stable and public lifestyles.

A related problem with risk assessment is the measurement of violence. Historically, violence has been measured via formal legal charges and convictions for violent crimes. However, doing so misses the majority of the violence perpetrated because most violence never results in legal charges. Even studies focusing on violent recidivism have found different results using two different official criminal databases (Barbaree, 2005; Seto & Barbaree, 1999). The differences between recorded legal charges and actual violence must only be greater. Studies have sought to gather additional self-report

data from research participants as well as significant others around them (Monahan et al., 2001) in order to improve on this problem. Nonetheless, measuring violence remains problematic.

Our initial discussion of a definition of violence also highlighted one of the problems with studying violence risk assessments. There is a great deal of variability in the definition of violence (Edens & Douglas, 2006). Many people include verbal and physical aggression as violence. Some only define violence in terms of legal convictions. The difficulty comes in comparing results across studies that have divergent definitions of violence and in relying on the convergence of these studies to identify appropriate predictors of violence. If two studies conclude very different things, it may be because their outcome measure, violence, is very different. There may even be different predictors of different severity levels of violence. X list of variables may predict murders and Y lists of variables may predict slap fights at bars.

Another problem is the low base rate of violence (Wollert, 2006). Violence is not a frequently occurring event and therefore it is difficult to study and maintain accurate estimates of risk. If the **base rate** or frequency for violence is 10%, a prediction that no one would become violent would be accurate 90% of the time. Why would a forensic psychologist ever predict violence if the only goal was accuracy? Because there are numerous other goals such as protecting the public, and forensic psychologists are not about to start playing the odds. Furthermore low base rates make it difficult for researchers to get a clear indication of the variables that are related to violence. Although there are ways to get around this problem such as using statistical techniques (e.g., Receiver Operating Characteristics) that are less tied to base rates (Mossman, 1994), and lengthy follow-up periods (e.g., 10 years), it is still an issue that continues to hamper violence risk assessment.

When Are We Good at Assessing Risk?

There are also a number of situations in which forensic psychologists are good at assessing risk for violence. As the literature has developed, it has become clearer that forensic psychologists are good at assessing risk for short periods of time (Mossman, 1994). It is much easier to assess whether a patient is going to become violent over 48 hours or 14 days than over 48 months or 14 years. A number of factors can change the longer the follow-up period required. An individual may lose his job, get divorced, start drinking alcohol again, or stop taking psychiatric medication. The longer the period of time a single risk assessment administration is to cover, the more room for potential error.

We are also good at assessing risk for people if we have adequate information about their past behavior, especially violent behavior (Elbogen, Huss, Tomkins, & Scalora, 2005). Individuals who are incarcerated for years in a prison or who are chronic patients in a mental hospital are likely to have extensive documentation that provides information about their past behavior. However, in situations where information is lacking or limited, assessment becomes more difficult. For example, assessing risk for a psychotic individual brought into an emergency room without

any identification is very difficult if you think back to the historical risk factors identified on the HCR-20 (Table 5.2). How many of those items do you think a forensic psychologist can identify in an unidentified psychotic patient? Forensic psychologists also are good at assessing violence for settings in which they have past data. A forensic psychologist is going to be much more accurate at assessing risk in a person who is released into a community if they have evidence of the general recidivism rate for that specific community.

Finally, it should not be surprising that we are more accurate in situations in which there are high base rates of violence. Generally, the closer the base rate for violence is to 50%, the more accurate risk assessments are likely to be (Quinsey et al., 2006). Assessing violence risk among the general public will always remain low because violence is relatively rare. However, base rates are heightened when risk is assessed in situations in which previously violent individuals are assessed, individuals who exhibit numerous risk factors are identified, or the assessments occur in institutional settings in which violence frequently occurs and is monitored.

Communicating Risk

A final aspect of violence risk assessment that is important to consider is the manner in which risk assessment is communicated to the courts either via testimony or written reports. At first glance, risk communication may seem relatively unimportant because it has largely been ignored (Heilbrun, O'Neil, Strohman, Bowman, & Philipson, 2000). One of the first discussions of the importance of risk communication occurred in Monahan and Steadman's 1996 article. They compared the process of violence risk assessment to weather forecasting, in order to highlight the different ways communication of risk can be important. Weather forecasts often explain the potential for routine weather anomalies in terms of probabilities. For example, there may be a 30% chance of rain for a given day. However, they explain more severe and problematic weather events in terms of categories. For example, there may be a tornado watch (tornado and severe thunderstorms are possible) or a tornado warning (a tornado has been spotted) in instances of severe weather. Monahan and Steadman (1996) also point out that weather forecasters explain the conditions that are likely to lead to the weather event and the steps that should be taken to avoid personal harm in the case of any occurrence. The legal system can only make better informed decisions about risk when mental health professionals communicate that risk in an effective and accurate fashion (Monahan et al., 2002).

There are a variety of ways in which risk can be communicated and the literature is identifying clear preferences among legal actors and mental health practitioners. Research to date has discovered that psychologists prefer to communicate risk in terms of risk management, identification of the relevant risk factors, and the potential interventions to reduce the threat of those risk factors. Psychologists also prefer to communicate risk in terms of categorical risk levels (high, medium, and low) over specific probabilities (a 10% chance of becoming violent). Furthermore, Slovic,

Monahan, and MacGregor (2000) found that clinicians were more likely to keep a patient hospitalized if the risk were communicated in terms of frequency (20 out of 100) compared to a probability (20%). Monahan et al. (2002) replicated these findings for clinicians working in forensic settings and also found that a more vivid depiction of past victim injuries further increased the likelihood of hospitalization.

These tendencies may have direct implications for the preferences of judges and juries. Monahan and Silver (2003) presented judges with information based on the different probability of risk associated with the different risk categories from the MacArthur Risk Assessment Study and asked them to identify the lowest level of risk at which they believed the individual fulfilled the dangerousness criteria for civil commitment. The judges clearly identified the 26% threshold as sufficient for civil commitment. It is interesting that the threshold judges preferred resulted in a 76.8% classification rate. However, this would mean civilly committing a little over one-third of the patients of which over 50% would have been nonviolent without any civil commitment (Monahan & Silver, 2003). However, Scott, Gilcrist, Thurston, and Huss (2010) found that the manner of risk communication was unimportant in a mock jury study.

At this time there is little consensus as to the best approach to take in communicating risk (Scurich & John, 2012). Scurich and John suggest that the form of communication should depend on the context in which the recommendation is being made. For example, the more adversarial a context the greater the allowance for more speculative testimony that can be challenged. Nonetheless, it remains a much understudied area with profound implications for the field. Not only should forensic psychologists strive to increase the accuracy of their assessments of violence risk, but they also should pay attention to the manner in which those determinations are communicated to the court.

Reflection and Review

1. Why is it important that risk assessment advance from the mere prediction of violence?
2. What is the best approach to the assessment of violence risk? Do context or other factors matter in that answer?
3. What are the implications for ignoring dynamic and protective factors and relying on static factors in the assessment of risk?
4. In what ways is it important to consult the research in regard to making assessments of risk?

Key Terms

actuarial risk assessment instruments
amicus brief
base rate
clinical risk assessments
dynamic factors
idiographic
nomothetic
protective factors
risk assessment
risk management
static factors
structured professional judgment

Further Readings

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6 Sexual Offenders

Chapter Objectives

1. Be able to identify the different uses of the terms *child molester* and *pedophile*
2. Discuss the different measures used to assess sex offenders
3. Identify the risk factors relevant to assessing risk among sex offenders
4. Differentiate the instruments used to assess risk among sex offenders
5. Understand the literature on the treatment of sexual offenders
6. Describe the nature of sexual violence in special groups of offenders
7. Explain the impact of legislation designed to reduce sexual offending

There may be no other area of forensic psychology that has undergone as dramatic a change in as short an amount of time as has clinical practice and research involving sexual offenders. The pattern parallels the passage of a host of U.S. legislation and decisions by the U.S. Supreme Court involving sexual offenders (Conroy, 2002). Often when dramatic change occurs in a very short period of time, it is accompanied by controversy, and this area of forensic practice is no different. Disagreement ranges from simple operational and diagnostic labels involving sexual offenders to the treatment and appropriate use of legal interventions (Conroy, 2002; Marshall, 2006; Quinsey, Harris, Rice, & Cormier, 2006). The majority of the literature and clinical practice has focused on adult male sexual offenders and as a result this chapter will focus largely on them, with some specific attention given to other special populations of sexual offenders such as juveniles, women, and the clergy.

What Is a Sexual Offender?

The term *sexual offender* is likely to bring with it a particularly negative connotation and a myriad of assumptions and stereotypes, both among the general public and forensic psychologists (Geffner, Franey, & Falconer, 2003). Most people think of horrific crimes like those of Jerry Sandusky, the former Penn State football coach (see Box 6.1), or John Couey. Couey kidnapped 9-year-old Jessica Lunsford from her own bedroom after breaking into her home, sexually assaulted her, and buried her alive. Terms like *predator* and *pedophile* are tossed about to describe all sex offenders. The term *predator* paints an especially vivid picture of a person out stalking his sexual prey as he walks among us. Unfortunately, that vivid picture tends not to be the norm for sexual offenders.

Sexual offenders are a heterogeneous group of offenders from a host of backgrounds and there is significant variety in the type and manner in which they commit their crimes. Some of these offenders assault children, some adults, and some both. Some sexual offenders' only crime may be the possession or distribution of child pornography, as they both deny and lack a history of contact offenses. The term *sexual offender* is largely a legal term used to label anyone who has committed a sexual offense. Most of the time these offenses involve contact offenses, characterized by the use of force or a threat to engage in a sexual

Box 6.1. Jerry Sandusky as a Case Example

Jerry Sandusky received national attention culminating with his 2012 convictions on multiple child molestation charges. He was formerly an assistant football coach at Penn State University and at one time was expected to take over for the legendary football coach, Joe Paterno. However, upon his sudden retirement in 1999 he devoted his attention to the charity he had formed, The Second Mile, more than 20 years before. The Second Mile was set up to assist underprivileged youth. During the later investigation, it was publicly speculated that his early retirement in 1999 was likely influenced by earlier allegations of child sexual abuse. However, the allegations did not result in criminal charges for another decade in part to an institutional cover up at Penn State as well as in the local community. Ultimately, Sandusky was convicted on 45 of 48 charges and later sentenced to 60 years in prison. The evidence indicated that many of his victims were boys involved in his charitable organization who had come from broken homes or were otherwise looking for structure and adult role models. Media reports revealed graphic sexual assaults by Sandusky in the community, his home, and even in the Penn State football locker room. The case is a clear example of a number of unfortunate factors repeatedly seen in child molestation. The children were groomed or progressively prepared to be assaulted as they became more comfortable with Sandusky. There was an institutional cover-up of the violence in order to protect the reputation of an institution and the individuals involved. It also took years until many of the victims were able to come forward, when they were well into adulthood, and it came as a surprise to many of their friends and family members that they had been assaulted as children.

act, but increasingly we are assessing and treating sexual offenders only accused of committing noncontact offenses such as the distribution and possession of child pornography. However, there is also significant variability in the manner in which different jurisdictions define sexual assault (Geffner et al., 2003). Consequently, sexual offenders are a group of offenders that include individuals who molest children, rape adults, expose themselves, and view other people engaging in sexual acts. Defining some of these distinct groups is often characterized by a mix of legal terms (e.g., *sexual predator*) and psychological terms (e.g., *pedophile*) that overlap but also can conflict in their precise meaning. As a result, it is important to start with a clear description of some of these differences.

The basis for much of the confusion in labels prescribed to sexual offenders is the use of paraphilic diagnoses. A **paraphilia** is a formal mental illness identified in the DSM-IV TR characterized by "recurrent, intense sexually arousing fantasies, sexual urges or behaviors" that involve (1) nonhuman objects, (2) suffering or humiliation of oneself or one's partner, or (3) children or other nonconsenting persons (American Psychiatric Association, 2000, p. 566). An individual need not actually perform an illegal act or even a legal behavior to be diagnosed with a paraphilia. The definition of *paraphilia* includes individuals who simply experience arousing fantasies or sexual urges and therefore an illegal act is not required, though it could be nearly sufficient for a diagnosis. Even engaging in a legal act could cause some to be diagnosed, if the activity is regarded as deviant or necessary for the sexual experience. For example, the character George Costanza on the 1990s television show *Seinfeld* once attempted to watch television and eat a pastrami sandwich while having sex. These activities are all legal but if he was not able to become sexually gratified without them, he could be diagnosed as suffering from a paraphilia. Nonetheless, the current focus on sexual offenders will include only those individuals who have performed an illegal sexual act, which has come to the awareness of the legal authorities.

The confusion is even more complex when the distinction between a specific paraphilia, pedophilia, and child molestation is examined. The term **child molester** is normally used to label anyone who has perpetrated a sexual crime against a child. Although the legal requirements tend to vary across jurisdictions, the age of sexual consent is between 14 and 18 years of age. A child molester would then be considered any adult, or anyone above the age of consent, who has engaged in a sexual act with anyone under the age of consent. However, a **pedophile** (APA, 2000) is someone involved in sexual activity or experiencing significant distress over sexual urges or fantasies involving a prepubescent individual (normally considered to be age 13 or younger). An individual could be a child molester and not a pedophile or in even more rare circumstances a pedophile and not a child molester. There are some mental health professionals that consider all child molesters pedophiles (Abel, Mittelman, & Becker, 1985), but this stance is certainly not universal (Marshall, 2006). Regardless, there appears to be a clear distinction between the two labels in terms of offending patterns (Marshall, 1998) and though pedophile suggests a mental illness in need of treatment, Marshall (2006) argues that all child molesters need treatment whether they are diagnosed as a pedophile or not. As a result of the potential distinction, the term *child molester* will be used as the general term and *pedophilia* as a more narrow term specifying a person with that particular mental illness. More recently, the term *hebephilia* is being used to describe sexual attraction to children early in puberty. The proposed

revision of DSM-5 included a hebephilic subtype but did not eventually make it into the final DSM-5. However, the inclusion of this diagnostic label has met with a great deal of controversy (see Blanchard, 2010; Blanchard et al., 2009; Franklin, 2010; Green, 2010).

Other definitional issues are less convoluted than the distinction between pedophiles, hebephiles, and child molesters. The second major category of sexual offenders, though it represents the greater percentage of sexual offenders (Quinsey et al., 2006), is that of rapists. Unlike child molesters, rapists do not have a parallel diagnosis in DSM-IV TR. Some forensic psychologists tend to use the diagnoses of sexual sadism and **paraphilia NOS** (not otherwise specified) to describe individuals who have perpetrated sexual assaults against adult peers, though the practice seems to occur without any reliability (Doren, 2002; Marshall, 2006; Marshall, Kennedy, Yates, & Serran, 2002). Again, there are also changes proposed currently in the DSM-5 to include Paraphilic Coercive Disorder that would be a potential controversial diagnostic label for rapists. The lack of a single encompassing diagnostic category for rapists probably represents the distinction between the crime of sexual assault and the notion that some sexual offenders may be driven in part by a mental illness to commit their crimes.

Other sexual offenders who less frequently are brought before the legal system tend to be referred to in terms of their paraphilias. **Exhibitionists** display their genitals; **frotteurists** rub themselves against other people; and **voyeurs**, or more popularly known as peeping toms, view other people nude or engaged in sexual acts. Rather than have hundreds of separate diagnoses listed in DSM, there are other paraphilias such as zoophilia (sexual intercourse with animals) that are classified under the paraphilias NOS category mentioned previously. It also should be noted that sexual offenders may suffer from multiple paraphilias or perpetrate on a diverse group of victims.

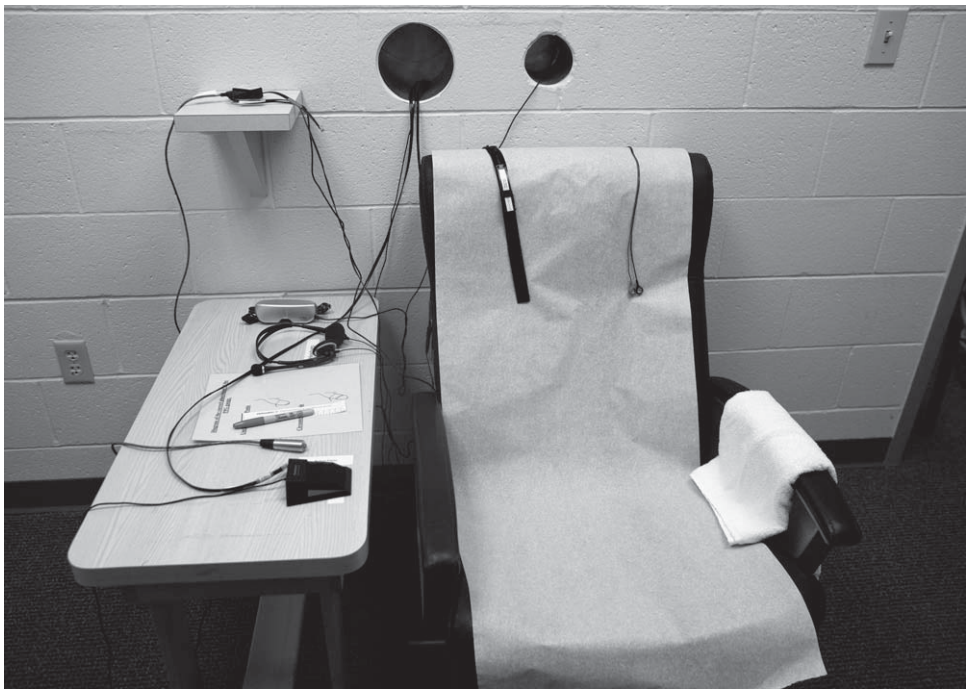
Assessment of Sexual Offenders

Convicted sexual offenders are typically evaluated in order to assess their future risk or treatment responsiveness. These assessments tend to focus on the phallometric measurement of sexual deviance, the underlying psychological characteristics that are likely to be related to an offender's sexual responsiveness and static and dynamic risk factors that are related to long-term recidivism. The nature of sexual offender assessment is frequently different than other forensic assessments. The forensic psychologist is not evaluating whether an offender has committed a particular crime but whether there is evidence suggesting treatment responsiveness or future risk. However, suspected sexual offenders may be inappropriately evaluated to assess whether they committed a particular offense. An individual may reveal a pattern of sexual deviance on a phallometric measure and have it used as evidence that the individual committed a particular crime. This type of clinical practice is similar to the trauma and profile evidence discussed in Chapter 3 and is just as flawed. Experts in the field strongly recommend against the use of sexual offender assessment results to suggest the guilt or innocence of an individual (Marshall, 2006; Quinsey et al., 2006) because it lies outside the scope of practice of forensic psychologists and is not supported by the psychological research. Using this evidence is like saying that

because someone eats steak, he is guilty of stealing it from the local grocery store. This same logic has been incorrectly used to suggest that because people exhibit sexual excitement to sexual violence, they are guilty of a particular sexual assault. Appeals court decisions also have found such evidence inadmissible and generally lacking scientific support (*Louisiana v. Hughes*, 2003).

Phallometric Assessment: Penile Plethysmograph (PPG)

Phallometric measures such as the **penile plethysmograph** (see Figure 6.1) are routinely used to determine the sexual interests of male sexual offenders (Marshall & Fernandez, 2000). A phallometric measure consists of some sort of sexual stimuli, monitoring equipment placed on the individual, and recording equipment. The sexual stimuli are either visual, auditory, or a combination of both. They normally consist of the presentation of audio or video stimuli that are deemed unusual or deviant in some manner along with neutral and sexually appropriate stimuli. Before an individual is exposed to these stimuli, he is connected to monitoring equipment. The monitoring equipment may consist of devices to measure heart rate, skin conductance (perspiration), and penile engorgement. Any response the individual gives to particular stimuli is then transmitted to the recording equipment and permanently stored either as a hard copy or on a computer.



Darren Hauck/The New York Times/Redux Pictures

Figure 6.1. A penile plethysmograph prior to use.

The underlying notion is that sexual offenders engage in their antisocial sexual behavior because of sexually deviant preferences that are exhibited when they view/hear similar sexual stimuli. The belief is that if an individual exhibits a response to deviant stimuli, he has similar urges and fantasies outside of the testing situation. For example, it would be quite appropriate for a heterosexual male to exhibit an accelerated pulse or penile engorgement if he views sexually suggestive pictures of women and listens to sexually suggestive conversations while doing so. Having a similar response to sexually suggestive pictures of small boys would be considered sexually deviant. Of course, there are legal limitations to the stimuli that can be shown. Nude pictures of children engaged in sexual acts are against the law and are not used anymore. However, pictures of children with accompanying auditory description of a sexual nature could be used.

Phallometric measures are potentially very useful because most sexual offenders are likely to deny attraction to inappropriate stimuli such as small children or violent sexual activity (Blanchard, Klassen, Dickey, Kuban, & Blak, 2001). Marshall (2006) even states that almost all reviews of the phallometric literature have come to positive conclusions regarding the use of phallometric measures with child molesters. Studies have found that phallometrics exhibit discriminant validity and are able to differentiate child molesters from nonoffenders (Chaplin, Rice, & Harris, 1995). Chaplin et al. (1995) compared 15 child molesters who had not been previously tested to 15 nonoffenders who volunteered from the community. They found very clear discrimination between the two groups, especially in relation to more coercive and brutal stimuli. Several studies also have supported the use of phallometric measures with rapists. In a meta-analysis, Lalumière and Quinsey (1994) examined 17 studies comparing rapists and nonrapists on phallometric measures. They concluded that the phallometric literature supported the discrimination between rapists and nonrapists across settings, though there was some difference across stimulus materials. There is some support for the valid use of phallometric measurement among sexual sadists also (Kingston, Seto, Firestone, & Bradford, 2010).

However, the accuracy of these procedures continues to be challenged (Conroy, 2002). Early beliefs were that phallometric measures would have wide utility among sexual offenders because all sexual offenders had learned or been conditioned to display arousal to their deviant interests. Further research suggested that a much more limited range of sexual offenders respond characteristically on these measures (Marshall & Fernandez, 2000). For example, phallometric testing has been largely confined to rapists and child molesters because of the limited utility with other populations. Furthermore, studies have had difficulty discriminating child molesters from other sexual offenders (Hall, Proctor, & Nelson, 1988). Others also argue that the discrimination between child molesters and nonoffenders is only clear when the child molesters have admitted their sexual deviance and they have multiple victims (Marshall, 2006). This finding is especially problematic in the group of offenders for which a validation of their deviant responses is most useful. Some suggest that phallometric measures are limited to child molesters diagnosed with pedophilia (Marshall & Fernandez, 2000) and research has found some difficulty in discriminating adolescent sexual offenders with female victims, compared to those with male

victims, from nonoffenders (Seto, Lalumière, & Blanchard, 2000). Overall, Looman and Marshall (2005) found that rapists do not exhibit preferences for rape stimuli over consensual sexual stimuli. Clegg and Fremouw (2009) have reviewed the literature on the use of phallometric measures among rapists and attempted to clarify best practice.

Furthermore, not all sex offenders respond adequately to the routine test stimuli. Poor response to the traditional stimuli can be because of variety of physical conditions. There is some evidence though that medication, such as Viagra, can be used to increase penile blood flow during phallometric testing and leads to more reliable and valid results (Kolla, Klassen, Kuban, Blak, & Blanchard, 2010). There are still concerns about whether the use of medications to make participants more responsive compromises the test though.

Psychological Assessment

In addition to phallometric procedures designed to assess sexual offenders, there are also a number of psychological approaches. Generally, psychological approaches to the assessment of sexual offenders have focused on trying to differentiate sexual offenders from nonsexual offenders on the basis of overall psychopathology. However, this research has resulted in limited utility for distinguishing among sexual offenders and other impaired non offender groups (Levin & Stava, 1987; Marshall, 1996). The focus has largely turned away from overall psychopathology toward areas that may serve as the basis for sexual offending. Accordingly, Marshall (2006) identified several target areas of sexual offender assessments, which we will touch upon. These areas can be assessed via clinical interview or other specific psychological measures.

Cognitive distortions, empathy, and sexual fantasies have been three of the most prominent areas of assessment among sexual offenders. Most measures have focused on the **cognitive distortions** of sexual offenders but the majority are fairly face valid and transparent so their purpose is fairly obvious. It is pretty easy to deny whether one masturbates to violent sexual fantasies or images of children. Nonetheless, it is important to assess the thinking errors that are part of the core process for sexual offenders being able to commit their crimes. Sexual offenders frequently create self-serving thought patterns that distort reality and allow them to avoid feeling responsibility for their crimes (Langton & Marshall, 2001). For example, an offender might state that his victim wore suggestive clothing even though the victim was 4 years old, the victim likes violent sex so the offender was obliging, or that his wife was not receptive to his advances so his daughter was an acceptable alternative. All of these ways of thinking are cognitive distortions that allow or encourage the individual to commit a sexual offense. Several scales have been developed to assess for the presence of cognitive distortions (Abel et al., 1989; Bumby, 1996; Burt, 1980; Nichols & Molinder, 1996), but the research is either unsupportive or is still underdeveloped. Even if more research is necessary to develop scales assessing sexual offender–specific distortions, cognitive distortions remain an important part of the assessment process via clinical interviews.

Victim empathy also has been a central component of most sexual offender assessments. Although there are general measures of empathy available (Davis, 1983), research suggests that sexual offenders don't have difficulty feeling for other people but do have a specific

inability to feel for their victim (Fernandez & Marshall, 2003; Fernandez, Marshall, Lightbody, & O'Sullivan, 1999), and there are not well-validated scales designed specifically for this purpose. As a result, clinical interviews and other collateral record searches may be the best option for forensic psychologists trying to assess the degree of victim empathy exhibited by sexual offenders.

The importance of fantasies in the commission of any violence is becoming of interest to forensic psychologists (Grisso, Davis, Vesselinov, Appelbaum, & Monahan, 2000) and especially the commission of sexual violence (Adherhold, Huss & Palarea, 2011; Skovran, Huss, & Scalora, 2010). There are even very crude measures that exist to assess deviant sexual interests via offenders' sexual fantasies (Baumgartner, Scalora, & Huss, 2002; Gee, Devilly, & Ward, 2004; O'Donohue, Letourneau, & Dowling, 1997). Baumgartner et al. (2002) used the Wilson Sex Fantasy Inventory to examine differences between child molesters and nonsexual offenders. As expected, the child molesters reported more pronounced fantasies across several subscales of the measure and overall reported higher levels of sexual fantasies than did nonsexual offenders from a forensic unit. Again, the research supporting the use of measures designed to assess sexual fantasies is preliminary and forensic psychologists are probably much more likely to use clinical interviews to assess sexual fantasies among sexual offenders.

Risk Assessment and Recidivism

Much of the early discussion in the sexual offender literature focused on whether sexual offenders were specialized offenders or sexual offenses were one of many crimes that general offenders committed (Lussier, 2005). This potential distinction is central to the discussion on the recidivism of sexual offenders and the manner clinicians go about assessing risk among individuals who have perpetrated sexual crimes.

Hanson and Bussière (1998) conducted a meta-analysis focusing on the risk factors related to both non sexual offending and sexual offending recidivism. Their study used 87 unpublished and published studies and all studies included information about sexual offenses, nonsexual violent offenses, and any reoffense. They divided all potential risk factors into either:

- demographic variables (e.g., age, marital status, education);
- general criminality (e.g., any prior offenses, juvenile delinquency);
- sexual criminal history (e.g., prior sex offenses, female child victim);
- sexual deviancy (e.g., phallometric assessment, any deviant sexual preference);
- clinical presentation and treatment history (e.g., failure to complete treatment, empathy for victims);
- developmental history (e.g., negative relationship with mother), and
- psychological maladjustment (e.g., any personality disorder, anger problems).

There were several interesting findings from their study (Hanson & Bussière, 1998). The strongest predictors of sexual recidivism were phallometric responses toward children and deviant sexual preferences. Prior sexual offenses, presence of a stranger victim,

early onset of sexual offending, related child victim, antisocial personality disorder, any prior offenses, age, never married, failure to complete treatment, and male victim also were related to sexual recidivism. In addition, there were several factors that were somewhat surprisingly unrelated to sexual recidivism given the focus of assessment and treatment among sexual offenders. Empathy for victims, denial of a sexual offense, low motivation for treatment, and being sexually abused as a child were all unrelated to sexual recidivism. Overall, only 13.4% of 23,393 sexual offenders recidivated within the average 4 to 5 year follow-up. However, Hanson and Bussière (1998) believe this figure is an underestimate of the percentage who actually committed additional sex offenses because of undetected offenses.

Similar factors predicted nonsexual violence and general recidivism. Recidivists tended to be young, single, and of a minority race. They also engaged in a variety of criminal behavior as a juvenile and as an adult. Recidivists of both types of crimes also were more likely to exhibit antisocial personality disorder or psychopathic characteristics. The number of prior sexual offenses and sexual deviancy were unrelated to nonsexual violent recidivism. Rapists were more likely to recidivate with nonsexual violent crimes than child molesters, thereby suggesting a greater likelihood of specialization for child molesters and more general criminal behavior for rapists. In general sexual offenders also were more likely to reoffend with a nonsexual offense than a sexual offense.

Hanson and Morton-Bourgon (2005) updated the earlier meta-analysis and again found that sexual offenders were less likely to recidivate for a sexual offense (13.7%) than a nonsexual offense (36.2%). Their findings also suggest factors that are related to repeat sexual offending may not be the same as those factors that are related to initiating sexual offenses. Although adverse family backgrounds and internalization of psychological distress are common in sexual offenders, they did not relate to sexual recidivism. The repeat sexual offender appears similar to the repeat nonsexual offender in that he leads an unstable and antisocial lifestyle but different in the sense that he tends to focus on sexually deviant thoughts during periods of stress (Hanson & Harris, 2000).

In general, recidivism rates for sexual offenders vary between studies and with the length of follow-up time. Most of the research suggests that recidivism rates for sexual offenders are similar to Hanson and colleagues' findings. They concluded that 10% to 15% of sexual offenders recidivate after 5 years. About 20% of sexual offenders recidivate after 10 years and 30% to 40% after 20 years (Hanson, Morton, & Harris, 2003). However, these figures are probably underestimated because they rely on legal charges and convictions. It should be clear that when we ever talk about recidivism, we are talking about *detected* recidivism; Hanson et al. (2003) state that it is reasonable to believe that these recidivism rates are underestimates by 10% to 15%. Nevertheless, it should be equally clear that not all sexual offenders reoffend and that evidence suggests that a minority of sexual offenders recidivate, especially within a decade after release.

In addition to the findings as they relate to sexual offenders generally, special care should also be given to differentiating among rapists and child molesters and even between specific types of child molesters. In general, **intrafamilial child molesters** are less likely to recidivate than rapists or **extrafamilial child molesters** (Hanson & Bussière, 1998). However, age of the offender was a significant intervening variable for child molesters

(Hanson, 2002). This finding is in keeping with our knowledge of the average age between different types of sexual offenders. Rapists tend to be younger than child molesters, and their risk for recidivism decreases as they age (Hanson, 2002). Extrafamilial child molesters exhibit minimal decline in risk until after age 50, with the highest risk between age 25 and 35 years old. Intrafamilial child molesters appear to be at greatest risk at substantially younger ages though their overall recidivism rate (8%) is lower than rapists (19%) and extrafamilial child molesters (17%) (Hanson, 2002). Intrafamilial molesters who offend against male victims are at lower risk than intrafamilial child molesters who victimize girls (Hanson et al., 2003). Nonetheless, Whitaker et al. (2008) found that similar factors predicted recidivism for rapists or child molesters.

Similar to the literature on general risk assessment, research is increasingly focusing on dynamic variables among sexual offenders. Given the increased focus on the treatment and continued confinement of sexual offenders until treatment progress is demonstrated, it could be argued that dynamic factors are especially important in assessing risk in sexual offenders (Doren, 2002). Hanson and Harris (2000) collected information on dynamic risk factors for over 400 sexual offenders from file reviews and interviews with their community supervision officers. Sexual offenders who recidivated within 5 years generally lacked social support, exhibited attitudes tolerant of sexual assault, led antisocial lifestyles, were uncooperative with supervision, and exhibited poor self-management compared to a similar number of sexual offenders who did not recidivate. The recidivists also exhibited elevated levels of anger and distress immediately prior to recidivism. In their previously described meta-analysis, Hanson and Morton-Bourgon (2005) identified similar results. Sexual preoccupations, impulsivity, antisocial attitudes, and intimacy deficits all exhibited small relationships with sexual recidivism. However, psychological distress was not related to recidivism. This finding could be similar to Hanson and Harris's (2000) finding that overall mood did not differ between recidivists and nonrecidivists in their sample. It may be that psychological distress does not predict recidivism in general but is an immediate precursor in sexual offenders who recidivate. Beggs and Grace (2011) have found that a host of dynamic factors are related to a reduction in sexual recidivism and that the sex offender version of the Violence Risk Scale (VRS-SO) specifically predicted sexual recidivism (Beggs & Grace, 2010).

Risk Assessment Instruments for Sexual Offenders

Similar to the debate regarding general risk assessment, there continues to be debate among forensic psychologists as to the role of clinical, structured, and actuarial approaches. Some of the same arguments against actuarial tools to assess sexual violence have been raised (Grubin, 1999; Sjöstedt & Grann, 2002) as well as the counterarguments against use of clinical and structured approaches (Hanson et al., 2003; Quinsey et al., 2006). Nonetheless, the proliferation of instruments (structured or actuarial) to assess sexual violence has been dramatic. Over the past decade or so there are easily a dozen different instruments in the literature and almost half that many have been the focus of considerable research. As a result, the focus of the current discussion will not be on rehashing some of the previous arguments regarding clinical versus actuarial assessment but on examining some of the

instruments currently in widespread use to assess sexual violence. Though there is an ever-increasing abundance of sexual violence risk assessment instruments (e.g., Minnesota Sex Offender Screening Tool–Revised, Rapid Risk Assessment for Sexual Offence Recidivism, Risk Matrix 2000, Sex Offender Need Assessment Ruling, Structured Anchored Clinical Judgment), our discussion will focus on the Sexual Violence Risk-20 (SVR-20), Sexual Violence Risk Appraisal Guide (SORAG), and the Static-99 (see Table 6.1 for the items on each measure).

Table 6.1. Items for Sexual Violence Risk Assessment Instruments

SVR-20	SORAG	Static-99
Sexual deviation	Psychopathy Checklist-Revised (PCL-R) score	Prior sexual offenses
Victim of child abuse	Elementary school maladjustment	Prior sentencing dates
Psychopathy	DSM-III diagnosis of personality disorder	Any convictions for non-contact sex offenses
Major mental illness	Age at index offense	Current convictions for nonsexual violence
Substance abuse problems	Lived with both parents to age 16	Prior convictions for nonsexual violence
Suicidal/homicidal ideation	Failure on prior conditional release	Unrelated victims
Relationship problems	Nonviolent offense score	Stranger victims
Employment problems	Marital status	Male victims
Past nonsexual violent offenses	DSM-III diagnosis of schizophrenia	Young
Past nonviolent offenses	Violent offense score	Single
Past supervision failures	History of alcohol abuse	
High-density sex offenses	History of sex offenses only against girls under 14 or if offender <5 years older than victim	
Multiple sex offense types	Phallometric test results	
Physical harm to victim(s)	Number of previous convictions for sexual offenses	
Use of weapons or threats of death		
Escalation in frequency or severity		
Extreme minimization or denial of sexual offenses		
Attitudes that support or condone sexual offenses		
Lacks realistic plans		
Negative attitudes toward interventions		
Other considerations		

The SVR-20 is the only structured approach to the assessment of sexual violence among the major risk assessment measures. The SVR-20 is a 20-item measure scored on a 0–2 points scale similar to the HCR-20 and PCL-R (Boer, Hart, Kropp, & Webster, 1997). In addition, when an item is coded as being present, the assessor should indicate whether there has been a recent change (as defined by occurring in the past year) in that item to make it more useful in risk management decisions. Although the SVR-20 is scored, the final point total does not correspond to a probability of risk (e.g., 80% of reoffending in the next 5 years) or to a summary risk level (high, medium, low). This approach is in keeping with the structured, but not actuarial, nature of the instrument. It provides guidance for the assessor to focus on the most important variables but does not restrict them to considering only those variables. There is even a location for "Other Considerations" to be taken into account when administering the SVR-20 and arriving at a final risk judgment.

In addition to the SVR-20, there are two major actuarial approaches to sexual violence risk assessment that have been more extensively researched. The SORAG contains the 14 items listed on Table 6.1, 10 of which are identical to the VRAG previously discussed in Chapter 5 (Quinsey et al., 2006). A score on the SORAG corresponds to nine different categories of risk, each of which has a corresponding probability of violent recidivism over seven and 10 years (Quinsey et al., 2006). The original purpose of the SORAG was not to predict sexual violence alone but to predict any violence among sexual offenders. The reason for this distinction will be discussed later.

The Static-99 is a combination of two previous measures. Four items from the Rapid Risk Assessment for Sex Offence Recidivism (RRASOR) and six items from the Structured Anchored Clinical Judgment comprise the Static-99. It is probably the most researched of any measure designed to assess sexual violence or violence among sexual offenders. Scores range from 0 to 12, but scores of 6 and above are treated identically (Harris, Phenix, Hanson, & Thorton, 2003). Each category of scores (0–6+) corresponds to a probability of recidivism for 5 years, 10 years, and 15 years. This approach is similar to the SORAG. For example, someone scoring a 7 falls into the 6+ category and has a recidivism rate of 39% over 5 years, 45% over 10 years, and 52% over 15 years. Any offender who scores a 7 falls into that same level of risk with those corresponding recidivism probabilities, irrespective of any additional characteristics that may differentiate them. The Static-99 has been revised to the Static-99R and now the Static-2002.

Each of these three instruments has demonstrated acceptable reliability and validity in a variety of samples and at this point it is difficult to make a conclusive statement that one approach has outperformed the other. There are studies finding that each of the three measures has equaled or outperformed the others without clear consistency among them (Barbaree, Seto, Langston, & Peacock, 2001; Craig, Beech, & Browne, 2006; de Vogel, de Ruiter, van Beek, & Mead, 2004; Sjöstedt & Långström, 2002; Stadtland et al., 2005). Moreover, these results also depend on the outcome variable. Studies examining sexual violence risk focus not only on sexual offenses but also on nonsexual violent offenses and nonviolent offenses. This practice is based on the difficulties often inherent in using sexual charges and convictions as outcome indicators. As Quinsey et al. (2006) suggest, all official

records are an underestimate of the actual rates of sexual violence not only because of the lack of reporting of all instances of sexual victimization but also because the sexual component is often removed from the final official conviction. An individual charged with sexual assault of a child may plead or be convicted not of a sexual assault but of simple assault, contributing to the delinquency of a minor, or some other more minor crime. As we have already discussed, sexual offenders also are likely to commit other offenses and rapists are as likely to commit a violent nonsexual offense as a sexual offense (Quinsey et al., 2006). As a result, scores on these measures are compared to several different outcomes. Ultimately, it may be as Craig, Browne, and Stringer (2004) suggest; different measures are more suitable for different situations. Because the Static-99 is composed entirely of static variables, the SVR-20 may be more useful in instances in which risk management is the central purpose. The SORAG may be more appropriate for use when assessing sexual violence and nonsexual violence because of its original purpose and the significant overlap with the VRAG, a measure designed to assess any violence. Hanson and Morton-Bourgon's (2009) meta-analysis compared approaches to risk assessment for sex offenders, not necessarily specific measures, and found that the actuarial approaches were superior to the unstructured approaches with the structured approaches generally falling in between these two extremes. However, they also concluded that results were influenced by the sample and the legal question, similarly to Craig et al. (2004).

Use of Sex Offender Risk Assessment Measures in the Field

Again, the prior research focused on the use of the most prominent measures for use among sex offenders in research contexts. A question previously raised in relation to psychopathy in Chapter 4 is whether they perform well in actual practice and if there are systematic differences among raters. One study that we examined when discussing the same issues in regard to the assessment of psychopathy compared scores on the Static-99 and Minnesota Sexual Offender Screening Tool-Revised (MnSOST-R), in addition to the PCL-R mentioned in Chapter 4 (Murrie et al., 2007). Overall, the differences in the scores between opposing experts was greater than expected. More importantly, score differences were generally in a direction that supported the party who retained the evaluators. These results suggest that there is indeed an allegiance effect for not only structured risk assessment measures, but actuarial risk assessment measures that should be less prone to bias given their systematic nature. Another field reliability study by Boccaccini et al. (2012) found that scores on the Static-99 differed by at least one point among pairs of evaluators in 45% of the sex offenders and by two or more points in 12.5% of the instances (scores range from 0–6 on the Static-99). Boccaccini, Murrie, Caperton, and Hawes (2009) also examined the same two ARAI relative to their ability to predict recidivism in a sample of almost 2000 sex offenders in routine forensic practice. They found that the ARAI performed worse than expected. In fact, offender characteristics such as age at release, prior arrests, and release type were either as effective or more effective than the ARAI in predicting future recidivism. However, Storey, Watt, Jackson, and Hart (2012) found good agreement between Static-99 ratings conducted during clinical practice for an outpatient sex offender program and trained researchers that later scored the instruments. Both groups

also performed equally well in predicting recidivism. Moreover, in those cases in which clinicians overrode or adjusted the Static-99 scores, something prohibited in the use of ARAI, the clinicians performed more poorly than if they had not adjusted those scores in predicting later recidivism. These results suggest that there may be differences in the use of ARAI in clinical practice and the research but at this time the research is insufficient to make a definitive conclusion.

Treatment and Management of Sexual Offenders

If you remember Chapter 2 on the treatment of criminal offenders, Antonowicz and Ross (1994) summed up the results of much of the field by stating that "a growing body of research literature attests to the fact that some rehabilitation programs are successful with some offenders when applied by some staff" (1994, p. 97). The sexual offender treatment literature was marked by reviews that were similarly pessimistic to the "no treatment works" conclusion of the early 1970s in the general offender treatment literature (see Furby, Weinrott, & Blackshaw, 1989) but the literature now contains research more in line with the Antonowicz and Ross quotation. The question remains, to what degree does the success of the general offender literature pertain to sexual offenders? Although there is overlap between different types of offenders in terms of the risk factors and the etiology of their criminal careers, there are also a number of differences highlighted in this chapter. Successful treatment and systematic interventions are increasingly important for sexual offenders as legislation has proliferated, targeting them as a special class of criminal offenders for which treatment is a component of the legal interventions.

Are Sexual Offender Treatment Programs Successful?

To date, the evidence regarding the effectiveness of sexual offender treatment programs is much debated. Advocates on both sides of the debate can point to individual studies that support their position. In fact, despite numerous reviews of the literature there is not a final consensus as to the effectiveness of sexual offender treatment. This research is further complicated by the low base rate of detected sexual violence (Hanson & Bussière, 1998) and the lengthy follow-up time required to obtain sufficient samples (Hanson et al., 2002). One act of sexual violence is intolerable because of the significant impact on even a single victim. However, zero recidivism is not a realistic goal at this time and therefore research has focused on significant differences in recidivism between treated sexual offenders and those who did not receive treatment.

One of the best controlled studies was conducted by Marques, Day, Nelson, and West (1994). Their study involved child molesters and rapists who had been hospitalized. Participants were placed into either the treatment group, the volunteer group (volunteered but did not receive treatment) or the nonvolunteer group (refused treatment). Treatment consisted of a 2-year cognitive-behavioral program using a relapse prevention model at a state hospital and a 1-year aftercare program. Initial results found that the treatment group exhibited the lowest rates of sexual and general recidivism compared to the other two groups.

Hall (1995) conducted the first meta-analysis of the sexual offender literature. He examined a small number of studies ($N = 12$) that included 1,313 sexual offenders and found a positive treatment effect. He discovered the sexual recidivism rate for treated sexual offenders was 19% compared to 27% for untreated sexual offenders. However, even in this small sample the studies were very different and comparison was difficult. Hall also found that studies with longer follow-up periods, with higher rates of sexual recidivism, that included outpatient therapy, and that were composed of cognitive-behavioral and pharmacological treatments were the most effective.

Another study attempted to answer the question as to the current state of the literature in a more definitive manner. Hanson et al. (2002) examined 43 different studies that assessed 9,454 different sexual offenders. Hanson and colleagues found that recidivism rates differed between treated sexual offenders and the comparison groups. About 12.3% of treated sexual offenders sexually recidivated (27.9% for general recidivism) and 16.8% of the comparison groups sexually recidivated (39.2% for general recidivism). In addition, they found that current treatment approaches were more successful at reducing sexual and general recidivism than older forms of treatment.

Finally, one question has been the degree to which sex offenders complete treatment, and which offenders fail to do so. Olver, Stockdale, and Wormith (2011) examined predictors of attrition or dropout in sex offender treatment programs. They found an overall attrition rate of 27.6% across studies. Significant predictors of dropout included younger age, more prior offenses, presence of antisocial personality, lowered intelligence, higher scores on risk assessment measures, and motivation. As a result, it appears that the highest-risk offenders are the ones most likely to drop out of treatment. Fortunately, as many have become more confident in the effectiveness of sex offender treatment, they have turned their efforts toward treating especially problematic groups such as those with intellectual disabilities (Lindsay, Michie, Steptoe, Moore, & Haut, 2010) and psychopathic sex offenders (Doren & Yates, 2008).

However, critics of the benefits of sexual offender treatment point to a number of methodological problems in the sexual offender treatment literature (Lalumière, Harris, Quinsey, & Rice, 2005). Many of the sexual offender treatment studies have been criticized for failing to use adequate comparison groups. For example, some studies have compared those individuals who completed treatment to those who dropped out or those who did not participate at all. Problems arise in that the treatment failures probably differed in terms of their motivation not only for treatment but also for future offending. Even those individuals who did not participate in treatment may be composed of individuals who refused treatment, not just those who were randomly assigned to the condition. Treatment dropouts are likely to also exhibit more characteristics related to risk for future recidivism.

There have been several critiques of the individual studies we already reviewed. Although Marques, Wiederanders, Day, Nelson, and van Ommeren (2005) initially found treatment differences, these differences were absent in the follow-up study for both rapists and child molesters. Not only did Hall (1995) use a small number of studies but the most impressive treatment effects occurred in those studies that compared treatment completers and treatment dropouts. When the studies comparing completers and dropouts were removed from the meta-analysis, there were no treatment differences (Harris, Rice, & Quinsey, 1998).

Although Hanson et al. (2002) found group differences, it is not completely clear that the group differences were the result of treatment as opposed to differences in the research designs of the included studies. Lalumière et al. (2005) have further criticized this meta-analysis because the removal of studies with random assignment of participants resulted in no differences between the sexual offenders who received treatment and the offenders who did not receive treatment. Lalumière et al. (2005) ultimately conclude that there are probably too few well-controlled studies for a meta-analysis to offer definitive conclusions on the effectiveness of sexual offender treatment programs. Though there may not be a clear consensus about the effectiveness of treatment for sexual offenders, the literature is not as pessimistic as Furby et al. (1989) were many years ago.

Components of Potentially Successful Programs

In addition to trying to assess the effectiveness of sexual offender treatment, there also is some evidence for the components that make up a well-designed treatment program. Early attempts at sexual offender treatment were often behaviorally focused, but soon treatment providers encouraged awareness of the cognitive components of sexual offending (Abel, Blanchard, & Becker, 1978) and an awareness of the relapse prevention model (Pithers, Marques, Gibat, & Marlatt, 1983). Cognitive and cognitive-behavioral treatments focus on the relationship between distorted thinking patterns and maladaptive behaviors. Cognitive-behavioral components focus on offender minimization, denial, and victim harm. The goal is to reduce the offender's denial and minimization of the offense and to come to terms with the harm they have inflicted on the victim (Marshall, 1996). Denial and minimization often function as a way to protect the offender from realizing the true consequences of his behavior and many programs believe these issues must be confronted for the sexual offender to effectively participate in treatment (Marshall, 1996). The cognitive-behavioral approach also addresses the attitudes and beliefs about women and children that are likely to result in sexual offense behaviors or sexually deviant interests that lead to the inappropriate behavior. Attitudes that completely sexualize women and view children as the sexual equivalent to adult peers are issues that are frequently addressed.

There are often a variety of deficits underlying the behavior of the sexual offender. For example, low self-esteem and sexual inadequacy often lead to deviant sexual interests (Marshall, 2006). By addressing the lack of self-esteem and sexual inadequacy, the deviant sexual interests may be diminished. Programs also target inadequate interpersonal skills and social functioning. Studies have found that programs that address issues such as anger control, assertiveness training, communication skills, and relationship skills are effective (McGrath, Cumming, Livingston, & Hoke, 2003). Another component often addressed in sexual offender treatment programs is substance abuse. Research suggests that substance abuse and dependence often accompany sexually inappropriate behavior and that it may act as a way to diminish the natural and cultural inhibitions against perpetrating sexually inappropriate behavior (Marques & Nelson, 1989).

Relapse prevention focuses on identification of the series of events that led to sexual offending behavior in the past and ways to replace the thoughts and behaviors that led to inappropriate sexual behavior. This approach was borrowed from the

substance abuse field. Just as an alcoholic would avoid bars, a child molester would identify locations where children would be present (e.g., circus, zoo, playgrounds) and similarly avoid them. In addition, child molesters need to realize that certain stressful events such as the loss of a job or argument with a partner might lead to sexually acting out and that they should identify appropriate coping responses when they are faced with these situations. This process is meant to alert the offender when he potentially poses an increased risk to reoffend so he can address the circumstances directly in order to avoid the events that lead to the inappropriate sexual behavior. In addition to the relapse prevention approach used in their program, Marques et al. (2005) recommended several improvements for their original treatment program. They recommended individually tailored treatment with regard to intensity and content, continued monitoring of treatment progress to ensure participants are truly getting the objectives of the program, and an individualized aftercare program.

Overall, these successful components suggest the same risk-needs perspective that we identified as applying to general offenders in Chapter 2. In fact, it appears that the RNR principles associated with general offender treatment hold true for sex offenders (Hanson, Bourgon, Helmus, & Hodgson, 2009). This perspective is aimed at reducing harm to the public. Nonetheless, an alternative approach called the Good Lives Model (GLM) has developed in the last decade. GLM argues that focusing on risk needs is necessary but not sufficient in itself. GLM argues that offenders must be properly motivated to change their ways and their human needs should be met (Ward & Stewart, 2003). This approach has been met with skepticism and referred to as paternalistic toward the sex offenders (Glaser, 2011), but some evidence does suggest it can be successful (Willis & Ward, 2011). However, there is not sufficient evidence to suggest that it is superior to the traditional risk needs approach alone.

Special Groups of Sexual Offenders

The discussion thus far has focused on adult male sexual offenders who have committed a contact offense because the overwhelming majority of sexual assaults are perpetrated by adult men. However, there are several special groups of sexual offenders that are receiving increased attention, whether from the media or the psychological literature. Each of these groups has its unique characteristics and challenges.

Juvenile Sexual Offenders

The U.S. Department of Justice report estimates that juveniles commit 35.6% of the sexual offenses against children, with the peak age of perpetration between 12 to 14, and that juveniles are more than one-quarter (25.8%) of all sex offenders (Finkelhor, Ormrod, & Chaffin, 2009). The problem of juvenile sexual violence is not limited to the United States, as 23% of individuals charged or convicted of sexual offenses in the United Kingdom are between 10 and 21 years old (Home Office, 1998). Despite the fact that juvenile sexual offenders represent a significant portion of all sexual

offenders and that many adult offenders begin their sexual offenses as juveniles (Abel, Osborn, & Twigg, 1993), there has been much less attention given to juvenile sexual offenders than adult offenders. Nonetheless, there has been an increase in the attention paid to juvenile sexual offenders (Zgourides, Monto, & Harris, 1997).

There are many unique challenges to assessing risk among juvenile sexual offenders. Our prior discussion clearly suggested there is a significant emphasis on static risk factors in risk assessment and juvenile offenders obviously have had less time to engage in these risk factors or even reach the normal developmental milestones at which they would be possible (e.g., marriage). As a result, there may be less information on which to base these decisions for juvenile sexual offenders. There is some evidence that the base rate of sexual violence for juveniles may be low in comparison to that of adult sexual offenders (Prentky, Harris, Frizzell, & Righthand, 2000), which would make the risk assessment even more difficult. However, the base rate for general recidivism for juvenile sexual offenders is much higher (Witt, Bosley, & Hiscox, 2002). Although there are a number of actuarial and structured instruments available for use with adult offenders and a significant amount of research supporting their use, the research on the reliability and validity for juvenile risk assessment measures is limited (e.g., Righthand et al., 2005). There also is disagreement about the application of adult risk factors to juvenile sexual offenders in the absence of well-established juvenile risk assessment measures (Witt et al., 2002). However, this practice is changing with the identification of some actuarial approaches to sexual violence risk assessment in juveniles.

Although juvenile sexual offending has been identified as a serious problem, the research has almost focused entirely on risk factors. We are only beginning to examine the reasons for adolescent sexual offending. Seto and Lalumière (2010) conducted a meta-analysis of the available studies in the area and found support for the idea that juvenile sexual offenders differ from juvenile offenders in general, suggesting a potential theory for sexual offending among them. They concluded that being a victim of sexual abuse, exposure to sexual violence, exposure to any abuse or neglect, social isolation, early exposure to sex or pornography, atypical sexual interests, anxiety, and low self-esteem all appeared to be special explanations for juvenile sex offending. Furthermore, though treatment programs have increased over the past 20 years, there has been little research evaluating the effectiveness of these treatment programs (Ertl & McNamara, 1997). Reviews of the literature suggest that juvenile treatment programs appear to focus on similar components to their adult counterparts (e.g., deviant sexual arousal, social skills, anger control, substance abuse, relapse prevention) and are largely cognitive-behavioral (Ertl & McNamara, 1997). Despite the limited information on treatment success, there does appear to be reason for optimism (Fanniff & Becker, 2006).

Female Sexual Offenders

The prevailing view has been that sexual offending was largely a product of male sexual behavior, but current events are increasingly confronting our society with the female sexual offender. Women with names such as Mary Kay Letourneau and Debra Lafave

Box 6.2. The Case of Mary Kay Letourneau

Headlines about the sexual assault of a child at the hands of an adult offender have unfortunately become commonplace. These reports typically involve male perpetrators, but women are more frequently perpetrating these crimes. For example, in 2005 Debra Lafave was a 24-year-old reading teacher in Florida who happily married before she was charged and convicted of illegal sexual behavior with a minor in 2005. In 1997, Mary Kay Letourneau became arguably the first case to make national and international news as a female sexual offender. Mrs. Letourneau came to national prominence after she was charged with statutory rape for engaging in an ongoing sexual relationship with her then 13-year-old pupil, Vili Fualaau. Mrs. Letourneau had taught Fualaau both as a second grade student and then as a sixth grade student. She later pled guilty and was sentenced to 89 months in prison. Two months prior to her guilty plea, Letourneau gave birth to Fualaau's daughter.

Not only was Mary Kay Letourneau's case unusual because of her gender but also because of the ongoing nature of her relationship with Vili Fualaau. Letourneau was released from jail after only serving 6 months of a suspended sentence under the conditions that she attend treatment and have no additional contact with Fualaau. However, she was found in a car with Fualaau with evidence that they were going to leave the country. She was returned to prison to serve out the remaining years of her prison sentence. Letourneau gave birth to her second daughter with Fualaau about 9 months after she had been originally released. She was ultimately released in 2004 after completing her sentence and then married Fualaau, who was 21 years of age. Since then the couple has lived together as husband and wife and she now goes by the name Mary Kay Fualaau.

have been appearing in newspaper headlines with increasing regularity because of their sexual crimes (Box 6.2). Although these sensational images have been prevalent in the media, there is relatively little research on female sexual offenders.

Although men continue to perpetrate sexual crimes at a much higher rate than women, the prevalence of sexual crimes perpetrated by women is unknown, with estimates ranging from 20 to 300 to 1 (Christiansen & Thyer, 2002) with about 2% to 5% of all convicted sexual offenders being women (U.S. Department of Justice, 1999). The FBI (2011) estimates that 27% of all juveniles arrested for sexual offenses are girls, but others indicate that only 1.5% of female sexual offenders reoffend (Cortoni, Hanson, & Coache, 2010). In addition, these data are probably underreports because of difficulty viewing women as sexual offenders. Studies indicate that female sexual perpetrators may be more prevalent among adolescents, around 5% to 7% (Camp & Thyer, 1994; U.S. Department of Justice, 2002). Furthermore, research suggests that female sexual offenders resemble male sexual offenders in a number of ways, including family backgrounds, peer relationships, sexual compulsivity, anger, and low self-esteem (Christiansen & Thyer, 2002). Contrary to many expectations, female sexual offenders may be more feminine than female nonsexual offenders (Pothast & Allen, 1994) and many female sexual offenders find the crimes sexually arousing, and not simply a way to fulfill a need for power and control (Matthews, Matthews, & Speltz, 1991). Female

sexual offenders also use a host of techniques ranging from violence (beating and burning) and threats of violence to emotional abuse when attempting to silence their victims (Saradjian, 1996; Wolfers, 1993).

It also appears the stereotypical teacher–student relationship portrayed in many media images is not the norm for female sexual offenders and they are a much more diverse group than previously believed. Christiansen and Thyer (2002) identified several different types of female sexual offenders. The *teacher/lover* offenders tend to seek out idealized relationships with young boys. *Intergenerationally predisposed* offenders are women from families with histories of several generations of sexual abuse. The *male-coerced* offender is coerced into sexual offenses by their partner and is often passive and powerless in interpersonal relationships. The *nonrelative caregiver/babysitter* offender perpetrates her sexual offenses as a formal babysitter or more informally watching someone's children on occasion. Finally, the *incestuous type* of offender is largely composed of women who perpetrate sexual violence against their children but also include other family relationships such as aunts and sisters. In potentially the largest single study involving female sexual offenders, Ferguson and Meehan (2005) examined 279 convicted female sexual offenders in Florida. They found that the overwhelming number of women used force (86.1%, with 17.3% using mutilation or disfigurement), 97.3% were the primary perpetrators, 67.7% of the victims were between 12 and 16 years of age, and they gradually became more violent with age. As with any group of offenders, female sexual offenders are heterogeneous with one study suggesting that about 16% of female sexual offenders are one-time offenders, 27% are generally antisocial women who offend sexually, and the majority (57%) are specialized female sexual offenders with multiple offenses who tended to commit noncontact offenses as well as contact offenses (Wijkman, Bijleveld, & Hendriks, 2011).

Clergy as Sexual Offenders

A group of sexual offenders that has received even more attention and public scrutiny than women are clergy. Although there have been incidents of clergy from a variety of religious backgrounds sexually molesting children, the crisis was especially acute in the United States for Roman Catholic priests (Plante, 2003). John Geoghan was a defrocked Roman Catholic priest who was a convicted child molester with over 100 accusations of molestation against him. While he was serving his 10-year prison sentence, Geoghan was strangled to death by another inmate in 2004. Although John Geoghan is often used as an iconic example of sexually offending clergy who assault altar boys and school-age children, little is actually known about clergy who sexually offend (Songy, 2003). The absence of research probably should not be surprising given the social conventions that are especially strong when it comes to clergy and sexually offending (Sapp, 2005) and the potential unease between mental health professionals and the Catholic Church.

There are a number of myths surrounding sexual abuse by clergy that research has addressed. Several hypotheses have been raised to explain for clerical sexual offending such as homosexuality, sexual celibacy, and a greater prevalence of sexual victimization among perpetrators. However, the limited research available has contradicted these potential reasons (Langevin, Curnoe, & Bain, 2000; Terry et al., 2011). Despite the view that child

molesters are rampant in the Catholic Church, the best available evidence suggest that only between 2% and 4% of Catholic priests are child molesters (John Jay Report, 2004; see Plante, 2003 for a review). Many believe that the offending clergy have sexual offense histories similar to John Geoghan, but research suggests that the overwhelming majority of clergy have fewer than 10 victims each (John Jay Report, 2004; Rossetti, 2002). Most of the victims in these instances are pubescent boys, not young children or girls (Plante, 2003). Although specific interventions or assessment strategies have not been empirically established for use with clergy (Songy, 2003), the available research suggests reduced recidivism rates comparable to nonclergy (Rossetti, 2002).

One of the most comprehensive studies ever conducted focused on sexual offending clergy in the Roman Catholic Church (John Jay Report, 2004). Researchers at John Jay College worked with the Roman Catholic Church to get a comprehensive picture of the nature of the problem in the United States. The study surveyed each diocese across the United States asking for every allegation, not criminal conviction or even credible allegation but every allegation, of sexual abuse from 1950 to 2002. This study was unique in that a small sample was not studied but the entire population of Catholic priests for over half a century was used. Results supported but also contrasted with some earlier findings. Most allegations were against parish priests who were age 25 to 39 at the time of the first allegation. About one-third of the priests suffered from substance abuse problems and only 6.8% reported being sexually abused themselves. Contrast this figure with earlier reviews that suggested a majority of offending priests were sexually abused (Plante, 2003). About 3% of the accused priests had 10 or more allegations against them and 40% of the incidents are alleged to have occurred in a home or parish residence. Even more surprising was that police investigated only 15% of these allegations, only 5% of the clergy were charged, and only 2% were convicted (John Jay Report, 2004). Ultimately, the second report from the John Jay efforts concluded that priests who commit these offenses could not be distinguished by psychological data, developmental and sexual history, intelligence data, or experience in the priesthood (Terry et al., 2011).

Online Child Pornography Offenders

As the Internet has evolved, it has begun to be used for the solicitation of potential victims and the distribution of child pornography thereby giving rise to an entirely new class of sex offender. As the use of the Internet to commit sexual crimes has increased, so has the discussion about whether online offenders are distinct from the traditional contact offenders or whether the Internet simply provides another outlet for their sexual deviance. Questions arise for both treatment and assessment in this regard. Many of the actuarial risk assessment tools have not been normed on child pornography offenders and are of questionable utility as a result. Moreover, it is unclear whether the traditional risk-needs treatment approaches or the more recent Good Lives Model (GLM) are more appropriate for these offenders. Early evidence suggests there may be important differences and similarities between online offenders and traditional contact offenders. Seto, Hanson, and Babchishin (2011) found that over half of online offenders (55%) admitted to a contact sexual offense, although only 12% had an officially identified contact offense. However,

Seto et al. also found only 4.6% of online offenders commit a new sexual offense during a 1.5- to 6-year follow-up period. Only 2% committed a contact sexual offense and 3.4% committed a new child pornography offense. Babchishin, Hanson, and Hermann (2011) concluded that online offenders have more self-control and greater psychological barriers (e.g., more victim empathy) than contact offenders. In a sample of 541 child pornography offenders, Eke, Seto, and Williams (2011) found that the best predictors of any new violent offending were a prior offense history and the younger age of the offender. Most studies about online offenders examine individuals who have been convicted of possessing and distributing child pornography. However, Seto, Wood, Babchishin, and Flynn (2012) appears to be the first study to compare men convicted of a contact sexual offense against a child, child pornography offenders, and offenders convicted of soliciting minors online for sex. They found that solicitation offenders engaged in less stable relationships and exhibited lowers levels of sexual deviation compared to child pornography offenders. Moreover, solicitation and child pornography offenders appeared to be similar on several risk factors, even though solicitation offenders were more similar to contact offenders in their interest in having sex with children.

Sexual Offender Legislation

Beginning in the 1990s there was an explosion of legislation targeting all sexual offenders. These laws have been aimed largely at detaining rather than rehabilitating sexual offenders and have frequently been preceded by public outcry after well-publicized sexual crimes (Garlund, 2005). Although the purpose of these laws is to increase public safety, the proliferation of sexual offender legislation offers a unique opportunity to examine the potential impact on the offenders themselves and the impact on the practice of forensic psychology. There have been three primary types of laws passed in the past decade: registration and notification laws, residency laws, and sexual predator laws.

Registration and Notification Laws

Sexual offenders are now required to register with local law enforcement in all 50 states of the United States (Tewksbury, Jennings, & Zgoba, 2012). This change in the law is directly attributable to the kidnapping and disappearance of a boy, Jacob Wetterling, in Minnesota in 1989. As Jacob was returning home with his brother and a friend, the children were approached by an armed man who commanded the other two boys to run away, after which he kidnapped Jacob. The crime remains unsolved and Jacob continues to be missing. As a result, the United States Congress passed the 1994 Jacob Wetterling Act, which encouraged states to create registration requirements for sexually violent offenses. Another crime against a child led to the formation of sexual offender notification laws in the United States. Megan Kanka disappeared from her home in New Jersey in 1994. A neighbor who had been convicted of two prior sexual offenses later confessed to the brutal kidnapping, rape, and murder of Megan. The United States Congress passed the Megan's Law in 1996, requiring the public

notification of sexual offenders. Though registration and notification laws are often separate, they frequently work in conjunction with one another across the United States. Registration laws require individuals to contact local law enforcement agents if they have been convicted of sexual crimes, whereas community notification provisions allow the government to make certain information available to the public. Public notification occurs in a variety of ways including posting names and faces of offenders on websites and notifying local schools, daycare centers, and nursing homes if a sexual offender moves nearby. The criteria for registration and subsequent notification varies across states with most states deciding it on an individual basis considering the risk of recidivism and the other remaining states ignoring the relevance of risk (Scott & Gerbasi, 2003). So far, the United States Supreme Court has upheld the constitutionality of these laws based on the challenges before them (*Connecticut Department of Public Safety v. Doe*, 2003). The question remains though: are these laws are beneficial?

There have been numerous objections to these laws that originally were proposed and passed with the intent to protect society. These laws fail to take into account the difficulty a sexual offender may face integrating back into society and the additional burden these procedures place on him that may increase the risk for reoffense (Edwards & Hensely, 2001). The sexual offender typically copes with additional stress by retreating into his sexually deviant thoughts and behaviors. Those laws that are based on identifying a subset of sexual offenders for inclusion as sexual offenders who must register or are subject to notification often rely on risk assessment procedures that are untested or have limited support. Many states have created their own risk assessment measures with unknown reliability or validity in the peer-reviewed psychological literature. Concerns also have been raised about the potential impact on the family and children of known sexual offenders. Children of registered sexual offenders may now be exposed to emotional abuse from peers, victims may now be subject to unwanted attention because of the public notification, and some states have seen a decrease in the reporting of incest offenses and juvenile sexual offenses because families are unwilling to face the possibility of negative publicity for their family (Edwards & Hensely, 2001; Freeman-Longo, 1996; Winick, 1998). There is even concern that public notification laws will simply shift the burden to areas where the sexual offender is unknown, increase the likelihood of more stranger-based crimes, and decrease the likelihood of self-reports and treatment-seeking behavior of institutionalized inmates (Edwards & Hensely, 2001). Nonetheless, sexual offenders have reported that despite the potential embarrassment over notification laws, they are likely to increase their incentives to avoid reoffense and increase their commitment to treatment (Elbogen, Patry, & Scalora, 2003).

However, an evaluation of Washington's community notification law found that it had little impact on reducing sexual or general recidivism but did speed up the time between an offense and an arrest of a suspect (Schram & Milloy, 1995). In addition, Tewksbury et al. (2012) found that New Jersey's law was unrelated to whether offenders recidivated. Sandler, Freeman, and Socia (2008) examined all sex offenders in New York from 1986 to 2006 in order to assess if New York's law had any impact on recidivism. They found that 95% of sex offenses during those 20 years were by first-time offenders, and the registration and notification law had virtually no effect. However, other studies

suggest that these laws may have an overall reduction in recidivism (Prescott & Rockoff, 2008). Drake and Aos (2009) stated that these laws may not act as a specific deterrent to sex offenders under supervision but may have a general deterrent effect.

Residency Laws

Residency laws are separate from registration and notification laws, but their aims are similar: to keep potentially dangerous individuals away from potential victims. Residency laws vary tremendously but generally require that sexual offenders live anywhere from 500 feet to a quarter of a mile away from locations such as bus stops, schools, parks, and daycare centers (Levenson & Cotter, 2005). Concerns over the potential negative effects of residency laws arise for several reasons. The evidence clearly supports the idea that 90% of sexual assaults occur against known victims, not random strangers at local playgrounds and schools. Research has found that child molesters who reoffend tend to be scattered across a community, not overly represented near these target areas (Colorado Department of Public Safety, 2004) and sexual offenders may be more likely to travel outside of their neighborhood for victims (Minnesota Department of Corrections, 2003). However, studies remain only preliminary and are far from conclusive. Legislation also may make it impossible or nearly impossible for sexual offenders to find housing and therefore increases the odds of them clustering in already high-crime areas or increases the stressors that lead to reoffense (Levenson & Cotter, 2005). Sexual offenders have reported that housing restrictions are likely to increase their isolation, increase financial hardships, and decrease their overall stability (Levenson & Cotter, 2005). Moreover, in one study it was found that over 90% of registered sex offenders were living in restricted areas (Berenson & Appelbaum, 2011). Duwe, Donnay, and Tewksbury (2008) analyzed the offense patterns from every sexual offender released in Minnesota for 12 years and found that not a single one of the sex offenses would have been prevented by restrictions in the sex offenders' residency.

Forensic psychologists are routinely asked to assist as a result of these laws, most notably the registration and notification laws. Frequently offenders violate the terms of these laws or their parole/probation to abide by these laws and a risk assessment is requested before any adjudication or even prior to additional sentencing. In one instance, I evaluated an individual who was charged with statutory sexual assault when he was 19 years old and had registered for over 15 years as a sex offender, but one of the conditions was that he inform law enforcement of any change in residency. He moved from one state to another without informing anyone and was arrested for violating the terms of his supervision. During the evaluation I was asked to assess his potential for future sexual violence prior to any sentencing by the court.

Sexually Violent Predator Laws

Sexually violent predator (SVP) laws tend to be the most controversial and the most complex of the recent sexual offender legislation. At least 20 states and the District of Columbia have passed SVP laws that provide for the identification and civil commitment

of identified sexual offenders (Fabian, 2011). SVP laws tend to be more limited in scope and only seek to identify those sexual offenders who are the most dangerous. Despite potential concerns that the majority of sexual offenders would be identified as SVPs, evidence suggests under 10%, if not under 5%, of sexual offenders across the relevant states have been identified as SVPs (Kendall & Cheung, 2004). Though these laws vary across jurisdictions, SVP laws focus on convicted sexual offenders and provide for the civil commitment of those individuals normally identified as mentally ill and likely to commit a future sexual offense if released. As a result, these laws are similar to civil commitment, which we will discuss in Chapter 7. However, they especially target convicted sexual offenders, not any person who may be mentally ill and dangerous. Normally, sexual offenders who are potential SVPs are identified by local law enforcement or district attorneys and must receive an SVP hearing. During the hearing, both sides present evidence before a judge or jury that the individual should or should not be designated a **sexual predator** or sexually violent predator. If found to be a sexual predator or sexually violent predator, the person is institutionalized after he has served his criminal sentence and receives treatment until he is no longer deemed to be a sexual predator (Fitch & Hammen, 2003). Texas is the lone exception where SVPs are committed as outpatients, and in Virginia and Arizona SVPs can be committed as outpatients or continue their institutionalization as inpatients in a mental health facility (La Fond, 2003). Therefore, the term *sexual predator* indicates a sexual offender at heightened risk to reoffend after release from prison, not anyone who has committed a sexual offense.

SVP laws have been criticized for a variety of reasons. First, SVP laws provide for the continued incarceration of an individual who has already served his sentence for a crime. In essence, it has been argued that they are tried twice for the same crime. There is a prohibition against such practices, *double jeopardy*, in the Constitution of the United States (see Mercado, Schopp, & Bornstein, 2005). Specifically, these laws are based on the likelihood of future crimes, not because they have committed a crime and gone unpunished for it. It could be argued that SVP laws are similar to the movie *Minority Report*, starring Tom Cruise, in which he serves as a futuristic police officer who arrests people who are going to murder someone, as predicted by the premonitions of three special psychic individuals. In no other instance are convicted offenders institutionalized because they are likely to commit a particular crime instead of the commission of an actual crime. Third, others have argued that these laws amount to ex post facto laws or laws passed after the person has been convicted and are therefore unconstitutional (see Mercado et al., 2005). Despite these concerns, the United States Supreme Court has rejected these as constitutional challenges and found SVP laws to be legally appropriate (*Kansas v. Crane*, 2002; *Kansas v. Hendricks*, 1997).

Additional concerns relate to the assumptions about forensic psychology that are inherent in these laws. The law assumes that forensic psychologists can accurately predict the likelihood of future sexual offending with a sufficient degree of certainty that warrants continued institutionalization, potentially indefinitely (see Levenson, 2004). In Minnesota and Washington, where the first SVP laws were passed, very few individuals (less than 4%) identified as SVPs have been released and allowed back in the community (as cited in Fitch & Hammen, 2003). As a result, states have experienced a number of

housing problems and increased costs as their number of institutionalized sexual predators has grown (Fitch Hammen, 2003). The state of Washington built an entirely new facility simply for the purpose of housing these individuals (La Fond, 2003). California budgeted $47 million for their SVP program in its second year of existence (as cited in Fitch & Hammen, 2003). Many critics also point to the debate about the effectiveness of treatment for sexual offenders and question whether legal statutes can rely on the future release of someone because of a reduction in risk due to treatment when it is not clear that treatment is even effective (Janus, 2000). Despite these criticisms and potential consequences, SVP laws continue to be passed and are necessitating an ever-increasing presence for forensic psychologists.

Reflection and Review

1. Are the terms *child molester* and *pedophile* the same?
2. What are the limitations of penile plethysmographs in assessing sex offenders?
3. Do the risk assessment instruments perform well in the field when assessing sex offenders?
4. What are some of the misconceptions regarding clergy that sexually offend?
5. Do you believe the current legislation focusing on sex offenders is useful?

Key Terms

child molester
cognitive distortions
exhibitionist
extrafamilial child molester
frotteurists
intrafamilial child molester
paraphilia
paraphilia NOS
pedophile
penile plethysmograph
relapse prevention
sexual predator
voyeurs

Further Readings

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7 Civil Commitment

Chapter Objectives

1. Define *civil commitment* and identify the common criteria
2. Describe the civil commitment process and types of civil commitment
3. Discuss the role coercion may play in civil commitment
4. Describe the clinical practice involved in civil commitment
5. Identify the relevance of the right to refuse treatment and make one's own treatment decisions

Civil commitment, or involuntary hospitalization, begins our third section of this textbook. In this third section we will focus on three different aspects of mental health law. Mental health law deals with individual topics that are intended to address individuals who suffer from mental illnesses or potentially suffer from mental illness. Specifically, civil commitment, competence, and insanity are the three broad areas central to practicing as a forensic psychologist within mental health law. Each of these three areas plays a specific role and evolved for a variety of reasons. In particular, civil commitment was established to assist individuals who suffered from mental illness and were in need of treatment but unwilling to seek it themselves. The current chapter will focus on a number of different aspects of civil commitment including the elements that define it, the legal theory that guides it, and the clinical process involved.

What Is Civil Commitment?

Civil commitment typically refers to the involuntary hospitalization or mandated treatment of mentally ill individuals who need care and incapacitation because they exhibit

dangerous tendencies toward themselves or others. The legal basis for civil commitment is usually described as originating out of the legal doctrine **parens patriae** or parent of the nation. Under this theory, the state is obligated to act in a parenting capacity for those individuals who are unable to care for themselves. Accordingly, parens patriae is used as a basis for a number of legal provisions that involve minors, the mentally ill, and the elderly. As parens patriae relates to the mentally ill, it suggests that the state not only has a right but a duty to protect people who may be at risk to themselves because they suffer from a mental illness. It emphasizes mental illness or an inability to care for oneself. A contrasting but related legal doctrine is **police power**. Under police power, the state's prominent obligation is not to protect the individual from himself but to protect society from that individual. The highest duty would be to protect society from any danger that may put the general citizenry at risk. Police power normally emphasizes dangerousness to others and therefore places a premium on prediction of dangerousness instead of an inability to care for oneself.

These two legal doctrines have shaped the development of civil commitment legislation and practice since its inception, thereby contributing to the legal consequences of the process. Parens patriae served as a foundation for civil commitment laws prior to the latter half of the twentieth century. At the same time, civil commitment laws were largely based on a medical model that suggested the mentally ill could and should be treated for their disorders. Historically, the mentally ill were placed in mental health institutions for extended periods of time, if not the rest of their lives, at the discretion of mental health professionals. The basis for civil commitment under the notion of parens patriae was that the mentally ill were in need of treatment. Thus, it was in their best interest to allow the state to commit them to a facility where they could receive the proper treatment. In practice, these commitments generally required only the signature of one or two mental health professionals and did not even require the diagnosis of a precise mental illness or the presence of any dangerous tendencies. Parens patriae served as the theoretical basis for civil commitment until the 1960s. At this time, concern arose about the abuse of civil commitment and the realization that the institutionalization of citizens deprived them of significant rights. Mental health professionals lost their largely unchecked ability to civilly commit patients and the process became less entrenched in a medical model and more in line with legalistic notions. The 1960s were also marked by the widespread use of antipsychotic medications that allowed for the release of individuals who previously had been institutionalized their entire lives. Figure 7.1 shows a psychiatric hospital.

The 1960s and 1970s were characterized by a number of U.S. court cases in which limitations were placed upon the commitment process. For example, a federal court ruled in *Lake v. Cameron* (1966) that less restrictive alternatives should be considered instead of institutionalization. The widespread use of medication made fulfilling this opinion more realistic. In another case, *Lessard v. Schmidt* (1972), individuals facing commitment were afforded a number of procedural safeguards for their liberty such as notice of the impending civil commitment procedures, the opportunity to state their case, and the right to representation. Cases like these and the Supreme Court cases that followed

Peter van Beek/Hollandse Hoogte/Redux Pictures

Figure 7.1. Psychiatric hospital in Tbilisi, Georgia.

them represented attempts to protect individuals facing potential commitments and marked the end of the states' unchecked institutionalization of anyone who exhibited unusual behavior. Recognition that civil commitment involved a significant loss of liberty (*Humphrey v. Cady*, 1972) and that safeguards must be in place colored future Court decisions. In *O'Connor v. Donaldson* (1975), the United States Supreme Court concluded that a person not only had to be mentally ill but also dangerous before he could be civilly committed (see Box 7.1). This decision had profound scope of practice implications, given the lack of research supporting risk assessment in any context. The intent of these legal changes was to reduce the number of people hospitalized. Evidence gathered since the widespread use of psychotropic medication and these legal decisions seem to suggest the intended effect. The number of people committed to public hospitals decreased between 1955 and 1965 from 558,000 to 475,000 (Kiesler & Simpkins, 1993), was 132,000 as early as 1980 (Brakel, Parry, & Weiner, 1985), and now is well below 100,000, despite the fact that the population of the United States overall has increased by 100 million people. These additional protections also seemed to signal a swing from parens patriae to police power. The focus has moved away from the presence of a mental illness and the informal authority of mental health professionals toward the more legalistic focus on dangerousness. A number of formal procedures were designed to protect the person facing civil commitment as a result. Table 7.1 summarizes some important case law in civil commitment.

Box 7.1. *O'Connor v. Donaldson* and the Case for Dangerousness

O'Connor v. Donaldson was an important case in mental health law, for civil commitment and even in the development of risk assessment. Kenneth Donaldson was a married man with three children prior to the onset of his significant mental health problems. His first difficulties began in his early 30s for which he was hospitalized and received electroconvulsive shock treatment. Upon release, he returned to living with his family until approximately a decade later. His second hospitalization occurred after he traveled to his parents' home in Florida and complained of paranoid delusions that he was being poisoned. His parents began commitment proceedings and he was soon committed to Chattahoochee State Hospital where he resided with dangerous criminals during his 15-year stay, even though he was never found to be a danger to himself or others. Donaldson further denied he was ever mentally ill during his stay at Chattahoochee and refused all treatment. He requested release on multiple occasions and even secured shelter and supervision if he was granted a release.

As a result of the hospital's continued refusal to release him, the American Civil Liberties Union (ACLU) took up Donaldson's case and argued that he had been deprived of his constitutional right to liberty because he was detained against his will and without treatment. The United States Supreme Court unanimously agreed and stated that a nondangerous person who is able to survive on the outside on his own or with the assistance of others should be released. Though this case was one in a series that helped bolster support for the mentally ill and was intended to fight some of the abuses present in the mental health system, one of the important implications for civil commitment was the Court's conclusion that a mental illness alone was not sufficient for the indefinite commitment of an individual. One interesting aspect of the case is that Donaldson was actually released prior to his case ever being heard by the Court and immediately obtained a job. He lived on his own for years before his case was heard by the Supreme Court in 1975.

Table 7.1. Important Case Law in Civil Commitment

Case	Result
Lake v. Cameron (1966)	Required that treatment should be in the least restrictive setting
Lessard v. Schmidt (1972)	Commitment proceedings must include the same procedural safeguards as criminal proceedings such as a notice of the impending civil commitment procedures and the right to counsel
Wyatt v. Stickney (1972)	Established the right to receive treatment for individuals civilly committed with a realistic chance of improvement
O'Connor v. Donaldson (1975)	An individual must exhibit dangerousness in order to be civilly committed
Addington v. Texas (1979)	The standard of proof in civil commitment proceedings is clear and convincing evidence
Zinermon v. Burch (1990)	Mentally ill individuals are not able to give consent for voluntary admission

Criteria for Civil Commitment

In order to be civilly committed, a person must be mentally ill and dangerous. Although some states include additional criteria, the presence of a mental illness and the likelihood of future dangerousness represent universal criteria for commitment. However, there are several nuances to both of these criteria in the practice of civil commitment.

Mental Illness

The more prominent and long standing of the two criteria is the presence of a mental illness. However, there are several potential problems that immediately arise with this seemingly straightforward criterion. One question is whether the legal or medical bases for a mental disorder are used for civil commitment decisions. Is there a difference between the legal definition of mental illness and the medical or mental health definition? Practically speaking, there is a difference between the two with the legal definition of mental illness being narrower. Typically, when the term *mental illness* is used, mental health professionals identify disorders that are commonly found in the DSM. This practice leads to an inclusive list and encompasses almost every construct that is generally accepted by the mental health field as constituting a mental illness. However, the law generally picks and chooses mental illnesses it views as appropriate for a particular legal determination and is ambiguous about defining mental illness (*Foucha v. Louisiana*, 1992). Civil commitment is no different. Mental disorders such as mental retardation, substance abuse and dependence, antisocial personality disorder, and even all personality disorders are routinely excluded from consideration as insufficient to meet this criterion under civil commitment statutes. These mental illnesses may be excluded from the legal definition of mental illness because they are chronic, believed to lack effective treatment, perceived as a matter of personal choice and control, or intertwined with antisocial or dangerous behavior that is characteristic of the second criterion for civil commitment. The reason for exclusion does not necessarily matter to the practicing forensic psychologist though, as long as she realizes there are legal limitations to the mental illnesses considered for civil commitment.

Another potential problem with the use of mental illness as a criterion for civil commitment is the seriousness of the mental illness. For example, personality disorders may be excluded from the legal definition of mental illness because they are seen as less severe or because they impair an individual to a lesser extent than other mental illnesses. Some statutes give no indication of the severity or level of impairment necessary for the civil commitment of an individual. Other statutes state that the mental illness has to impair someone to such an extent that he is unable to make decisions. Nonetheless, mental illnesses will impair an individual to a varying extent and the civil commitment laws seem to suggest that this aspect is part of the definition of mental illness.

Another potential problem with mental illness is the presence of the hindsight bias. Who is more likely to be seen as mentally ill, a person who is not currently institutionalized and has never been institutionalized or someone who is hospitalized or even

Box 7.2. Focus on Research: Rosenhan's Study: Insane in Insane Places

David Rosenhan published the results of his famous experiment in the journal *Science* in 1973. Rosenhan's study involved a series of associates acting as pseudopatients attempting to gain admission to 12 different psychiatric facilities in multiple locations across the United States. His associates presented themselves to hospital staff with a single fake symptom that consisted of an auditory hallucination. All of them claimed to hear a voice that was unclear but seemed to be saying words like *empty* and *thud*. They did not claim any other symptoms and all other information they reported was correct, except for their names and employment information. If admitted, they were to act normally and report they no longer heard the voices. All of them were eventually admitted, diagnosed with a major mental illness (seven with schizophrenia and one with bipolar disorder) and held anywhere from a week to almost 2 months. An interesting side note was that the patients in these very same facilities tended to be the ones who questioned whether the pseudopatients were faking their symptoms.

The publication of his research caused a great deal of discussion about its methods and the claim that it was an indictment of psychiatry in general. There also was a second part of the experiment that is often overlooked. Rosenhan repeated his experiment at a well-regarded hospital that had heard of the results and did not believe the same outcome would occur at their facility. The hospital agreed to allow Rosenhan to send pseudopatients to them over a 3-month period. During that time the hospital reviewed 193 patients and identified 41 of them as suspected imposters by at least one staff member (attendants, nurses, physicians, or psychologists), 23 by one psychiatrist, and 19 by one psychiatrist and one other staff member. However, Rosenhan had never sent any pseudopatients to the hospital.

being evaluated for hospitalization? Rosenhan's (1973) famous experiment may give us the answer to that question (Box 7.2). One of the lessons from this experiment was that there was a certain hindsight bias or labeling effect of anyone whose mental health might be questioned or institutionalized. When these patients presented themselves and certainly once they were admitted, there was a natural tendency for staff to view them in a way that was consistent with their hospitalization and their diagnosis.

Dangerousness

The second universal criterion for civil commitment is dangerousness, either a danger to self or a danger to others. As with mental illness, there is variability in the conceptualization of the nature of dangerousness. In terms of danger to others, most jurisdictions consider bodily harm to be the threshold requirement. However, some states suggest that danger to others could include property, other interests, or even emotional harm. Some jurisdictions even require an overt act for danger to others to have been met. In terms of danger to self, statutes are even more vague and may or may not equate

danger to self as suicidal attempts, gestures, or ideation. Some jurisdictions use the term *imminent risk of suicide* but still frequently leave imminent undefined.

Much like the mental illness criterion, problems also arise in addressing the dangerousness criterion for mental illness. As was discussed in Chapter 5, mental health professionals have historically had a great deal of difficulty predicting or assessing violence risk. This exercise has been especially problematic in committed psychiatric patients in part because of the controversy over the relationship between mental illness and violence. The literature has not always been clear about this relationship and inaccurate stereotypes of the mentally ill have made the communication of the available information even more difficult when relationships were found. The relationship between mental illness and violence will be discussed in more depth later in this chapter. Nonetheless, assessing risk is still difficult among civil psychiatric patients.

A second reason the assessment of risk is difficult is because of the use of actuarial and clinical approaches. Though an argument can be made for the superiority of actuarial approaches over clinical assessments of risk (Quinsey, Harris, Rice, & Cormier, 2006), the use of actuarial approaches is difficult when civil commitment decisions are necessary (Elbogen, Huss, Tomkins, & Scalora, 2005; Elbogen, Williams, Kim, Tomkins, & Scalora, 2001). Often these situations require fairly immediate decisions if an individual is presented for admission to a mental health facility or hospital emergency room. The individual may be uncooperative, their records unavailable, and their historical information generally difficult to obtain. As a result of the need for immediate decisions, clinical predictions are often the norm and therefore forensic psychologists are left with an approach that may be less accurate.

Related to the dangerousness to self requirement is the term **grave disability**. Most jurisdictions explicitly consider the presence of a grave disability to be sufficient for danger to self and all jurisdictions consider it in making this determination. Someone is normally considered gravely disabled if he or she is unable to care for himself or herself and provide for his or her own basic needs. It is interesting that grave disability is the most frequent reason for civil commitment over dangerousness and that young persons (21–35), not the elderly, are those who are typically committed on the basis of a grave disability (Turkheimer & Parry, 1992). One reason that mental health professionals may be more comfortable with a designation of grave disability is that it requires proof of a current deficit in one's ability to care for oneself, not a future or predicted inability (Wexler & Winick, 1991).

Furthermore, there is a connection between these two elements of civil commitment. Many states explicitly state that the dangerousness has to be the "result of a mental disorder." Therefore, not only does a person have to refuse treatment but must do so because of their level of impairment, not because of a religious belief or other conscientious objection. As Strachan (2008) points out, a person may suffer from schizophrenia and be facing serious harm because he lives on the street and is routinely assaulted. However, if the person refuses treatment because he is a Christian Scientist, instead of because of the delusional beliefs related to his schizophrenia, he may not be eligible for civil commitment in certain jurisdictions. This is a good example of the importance of a forensic psychologist knowing the law and its impact on a forensic conclusion.

Need for Treatment

Another criterion for civil commitment that is not as universal as the presence of mental illness and dangerousness is the need for treatment. Although the need for treatment was the original basis for civil commitment, it is not recognized as sufficient to take away an individual's liberty. Many jurisdictions continue to include the need for treatment as an additional criterion for civil commitment but it is not a sole criterion in any of them. Frequently, the need for treatment is incorporated into the mental illness criterion so that the presence of a mental illness is not sufficient to meet that criterion. In these instances, one may be civilly committed and one's loss of liberty justified only if one's mental illness can be treated.

Process of Civil Commitment

Though procedures differ across jurisdictions, there are generally two paths for civil commitment in the United States (Sales, Miller, & Hall, 2005). The first path tends to be more formal and includes a petition to the court for court-ordered commitment, court review of the petition and potential formal evaluation, a potential hearing after the evaluation has been conducted, and then commitment of the individual, if it is warranted. Because of the long-term consequences of depriving a civil commitment candidate of his freedom, there are numerous protections involved in an **extended commitment**. Depending on the jurisdiction, these rights may include written notice of a commitment hearing, the right to counsel, the opportunity to call witnesses, and the right to a jury trial or to have a judge make the final decision. However, the reality in these situations is often inconsistent with the legal protections in place. It is common for attorneys to become less adversarial in these situations and act more in the best interests of the client (Perlin, 1992). In one study, researchers contacted attorneys who were eligible to represent clients at mental health hearings. Attorneys were asked about their preparation and behavior during each of 299 different mental health hearings at a maximum security hospital. Results demonstrated that attorneys exhibited more adversarial behavior in criminal hearings than civil commitment hearings (Leavitt & Maykuth, 1989). Although this attitude may seem natural when thinking about the care and treatment of the mentally ill, would a similar attitude be tolerated in attorneys representing criminal defendants who have a serious history of antisocial behavior and are in need of rehabilitation or punishment?

Commentators have argued that the adoption of this paternalistic approach voids the protections that have been put in place to eliminate earlier abuses. Furthermore, there may be significant consequences when a client loses faith in the legal system and the clinicians involved in the case (Winick, 2001). The informality associated with the supposedly more formal path to commitment is clearly suggested in the average length of civil commitment hearings—approximately 12 minutes (Leavitt & Maykuth, 1989). Even though the U.S. Supreme Court has required that the standard of proof is clear and convincing evidence (*Addington v. Texas*, 1979), there is not a requirement that

the burden of proof be placed on the states. In some instances, the patient has the burden of proving he or she is not mentally ill and dangerous. Despite the tenor of the extended commitment process, a civil commitment candidate is usually facing commitment anywhere from a couple of weeks to a year, depending on the jurisdiction (Johnson, 2004). There also is a period of reevaluation that takes place after the initial commitment has expired.

The second path is through an **emergency commitment**. A law enforcement officer or mental health professional can typically authorize an emergency commitment that may allow hospitalization anywhere from 24 hours to several days. Some states even allow for up to 30 days before any formal hearing needs to be scheduled. Emergency commitments tend to be much less formal and there are fewer protections in place for the person facing civil commitment. Usually the commitment candidates are informed of the duration of the commitment, that they are entitled to a hearing at the end of the commitment, and when their right to counsel becomes available. As with extended commitments, a reexamination of the initial commitment status of a person must take place prior to the expiration of the emergency commitment in order to continue commitment of the individual. However, some data suggests that briefer emergency commitments (48 hours) were correlated with longer hospital stays, more involuntary commitments later, and a reduced likelihood of a dismissal of the commitment order (Wanchek & Bonnie, 2012). Wanchek and Bonnie argued that these results suggest that there is a minimum amount of time that is necessary to effectively evaluate individuals and that an extension of the amount of time allowed before a formal court hearing must be scheduled (e.g., to 72 hours in Virginia) is advisable. These results again suggest that the law can have a real impact on the lives of people involved in forensic issues.

Outpatient Commitment

For the most part, civil commitment has historically meant inpatient treatment where the person is hospitalized for 24 hours each day. Inpatient commitments typically include medication and individual or group therapy. However, as civil commitment laws were more influenced by the police power doctrine and the **deinstitutionalization** movement that began in the 1950s and 1960s, outpatient commitment became a more viable alternative. In outpatient treatment, the individual is not hospitalized 24 hours a day but is still mandated to some form of treatment while maintaining significant freedom. An outpatient commitment may dictate that an individual see a psychiatrist regularly, attend treatment sessions on a weekly basis, or even participate in a day program that consists of treatment during a regular business day. Outpatient treatment also follows the intent of other Supreme Court decisions that have encouraged commitment to the least restrictive alternative (e.g., *Olmstead v. L.C.*, 1999). In the case of a less restrictive alternative, a person who has been civilly committed must be treated using the approach that allows the least restriction on their personal liberty and freedom while still being effective.

The conditions for outpatient civil commitment may vary from inpatient standards. At present, the majority of jurisdictions in Canada and the United States have outpatient commitment procedures in place (Allbright, Levy, & Wagle, 2002; Douglas & Koch, 2001a).

Most of these jurisdictions use the identical criteria for inpatient or outpatient commitment. However, other jurisdictions' criteria differ anywhere from slightly to significantly between outpatient and inpatient commitments (Allbright et al., 2002). Some states exclude dangerousness as a criterion and others include a need for treatment to prevent future deterioration that would result in dangerousness. New York has one of the more frequently discussed outpatient commitment laws in the United States. Kendra's Law was named after a Kendra Webdale, who was pushed from a subway platform into an oncoming train and killed instantly. Her attacker, Andrew Goldstein, had been previously diagnosed with schizophrenia, had a violent assault history, was not taking his prescribed medication, and had been recently dismissed from a psychiatric hospital. Kendra's Law established several criteria that must be met for an individual to be committed as an outpatient: (1) suffer from a mental illness; (2) be unlikely to survive in the community without supervision; (3) have a history of poor treatment compliance that has necessitated hospitalization and is unlikely to participate in treatment currently because of a mental illness; and (4) be in need of outpatient commitment to prevent a deterioration or relapse that would result in serious harm to the patient or others. Outpatient commitment under Kendra's Law lasts for 6 months and can be continually extended for a year (Perlin, 2003).

There are generally three different forms of outpatient commitment. There is **traditional outpatient commitment**, **preventative commitment**, and **conditional release** (Schopp, 2003). *Traditional outpatient treatment* as an alternative to inpatient treatment meets the criteria for civil commitment, but individuals committed under it are allowed to seek treatment on an outpatient basis as a less restrictive alternative to inpatient care. *Preventative commitment* is more controversial because individuals do not typically meet the criteria for civil commitment but there is an expectation that they will deteriorate in the future and meet the requirements for civil commitment. Therefore, the argument is that intervention is necessary to prevent the deterioration and future inpatient hospitalization (Schopp, 2003). North Carolina has a preventative commitment statute in which an individual may be committed for 90 days, with 180 days renewals, if the candidate is mentally ill, able to survive in the community with support, in need of treatment, and impaired in his or her ability to seek treatment (Allbright et al., 2002). *Conditional release* is a form of outpatient commitment that occurs at the termination of inpatient hospitalization. Individuals who have been committed as inpatients are released on the condition that they participate in treatment as an outpatient. If they fail to comply with the conditions of the release, they are returned to the hospital as an inpatient.

Outpatient commitment was initially devised as an alternative to other methods. The belief was that outpatient treatment would decrease the number of hospitalizations, both involuntary and voluntary, and decrease the revolving door of patients often seen in psychiatric hospitals (Kress, 2000). It also was intended that outpatient alternatives would reduce the likelihood of criminalizing the mentally ill and involving them in the criminal justice system as a method for obtaining treatment (Kress, 2000).

Despite potential good intentions, there are significant concerns regarding outpatient commitment. Some believe that outpatient commitment encourages quick action and expedition of a process that deprives people of their freedom and thus is potentially

dangerous. In addition, outpatient commitment reauthorizes the power of mental health professionals (McGafferty & Dooley, 1990). Conditional release may give hospital staff the right to revoke a patient's outpatient commitment status and return her to the hospital. Others have voiced concerns regarding preventative commitment because the normally lesser commitment standards allow supervision of significantly more people who may not have anyone to advocate for them (McGafferty & Dooley, 1990). The advent of outpatient commitment was not solely because of concern about abuses in the inpatient commitment process. Financial concerns were another factor in the rise of outpatient commitment and financial pressures may dictate patient care instead of patient needs (Kress, 2000). Others reasoned that if candidates were dangerous enough to meet the criteria for civil commitment, they were too dangerous for outpatient civil commitment (Miller, 1987). All of these reasons have led to many people questioning the use of outpatient commitment as an alternative to inpatient care.

Empirical Examination of Outpatient Commitment and Other Changes in Commitment Laws

The question is often whether changes in the law have their desired effect. Outpatient commitment laws and the movement away from parens patriae and toward police power are no exception. Are these laws effective? In regard to outpatient commitment there are primarily two questions. Does outpatient civil commitment work as effectively as inpatient treatment? Second, does outpatient commitment perform better than voluntary treatment (Hiday, 2003)?

Early studies examining outpatient commitment were generally positive. They found that individuals who had been committed as outpatients were less frequently readmitted, spent fewer days readmitted, demonstrated greater medication compliance, participated in treatment longer, made more visits to community treatment programs even after their commitment expired, and showed better community adjustment (Hiday, 2003). However, these studies were naturalistic, often lacked adequate control and comparison groups, and had a number of alternative explanations for the phenomena they observed (Hiday, 2003). For example, individuals chosen for outpatient commitment could be better candidates for treatment in general because of treatment history or current social support (Hiday & Goodman, 1982). They may show better treatment effects for that reason rather than outpatient treatment actually being better.

Studies addressing whether outpatient commitment was superior to voluntary hospitalization were able to overcome some of these prior limitations in the outpatient versus inpatient studies (e.g., Steadman et al., 2001). One of the most extensive studies focusing on the second question was conducted by Marvin Swartz, Jeffrey Swanson, and their colleagues (Swartz et al., 2001). This study included random assignment of participants to either outpatient commitment or no outpatient commitment, as well as a number of other features to improve the study design and eliminate other explanations for any obtained results. All participants were individuals who had been previously involuntarily committed as inpatients and were either released as outpatient commits or released without that supervision. Outpatient commitment did not result in reduced

utilization of hospital services, but participants who received extended outpatient commitments had fewer readmissions, and fewer days in the hospital if they were readmitted (Swartz et al., 1999). Furthermore, a combination of extended outpatient services and frequent utilization of services did relate to a reduction in overall violence (Swanson et al., 2000). Quality of life is another indicator of treatment success, though a more abstract one. The utilization of outpatient commitment is not only related to hospital re-admission and criminal justice outcomes but is also related to improvement in general quality of life. Patients who underwent longer periods of outpatient commitment generally reported a greater quality of life (Swanson, Swartz, Elbogen, Wagner, & Burns, 2003a). Outpatient commitment has also been associated with fewer arrests for violent crimes (Link, Epperson, Perron, Castille, & Yang, 2011), reduced suicide risk, improved social functioning, no increases in stigmatization or coercion (Phelan, Sinkewicz, Castille, Huz, & Link, 2010), and greater access to both voluntary and involuntary mental health services (Swanson, Van Dorn, Swartz, Cislo, Wilder, Moser, Gilbert, & McGuire, 2010). A more recent examination of New York's outpatient law further supported earlier claims by finding reduced hospitalization, reduced length of stay, increased use of psychotropic medication, increase use of intensive case management, and greater use of outpatient services in general (Swartz, Wilder, Swanson, Van Dorn, Robbins, Steadman, Moser, Gilbert, & Monahan, 2010).

However, there are significant concerns about the utilization of outpatient commitment. For example, in both California and Florida outpatient commitment is rarely utilized. For example, outpatient commitment was only initiated 71 times in Florida over a 3-year period in which almost 125,000 commitment examinations were initiated and almost 42,000 people had two or more 72-hour involuntary emergency commitments (Petrilla & Christy, 2008). These results suggest that enacting an outpatient commitment option is not sufficient but that the law and the surrounding delivery system must be designed appropriately to experience any of the benefits that such states as New York have experienced.

Coercion of Civil Commitments

Coercion can mean the use of threats or force, medicating a patient against her will, or having police bring a patient to the hospital. Though there may not be a precise definition of coercion, there are several dimensions that have been taken into account (Wertheimer, 1993). These dimensions include the perceived availability of alternatives, strength of patient preferences for pursuing hospitalization versus alternatives, the type and intensity of the pressure placed on the patient, and the burden of choosing hospitalization. Moreover, coercion should be related to the context in which the behavior occurs, because what may be coercive in one context is not coercive in another (Wertheimer, 1993). Though coercion is an inherent part of civil commitment, there has been debate about the level of coercion that is appropriate and the true nature of coercion (Lidz, 1998).

Despite the positive effects associated with outpatient commitment, concern remains over the potentially coercive nature of it and the impact on treatment (Galon & Wineman,

2010). In fact, some research has supported these concerns about the increased coercion present in outpatient commitment compared to more traditional community treatment (Galon & Wineman, 2011). Furthermore, these concerns have extended to traditional inpatient commitments and voluntary hospitalizations. Estimates have generally suggested that upward of 30% of all psychiatric patients are involuntarily committed (Monahan & Shah, 1989), but even among the remaining 70% of individuals, most are not truly voluntary. For example, individuals classified as voluntary may have been hospitalized under threat of a formal civil commitment. A U.S. Supreme Court decision further complicates the distinction between voluntary and involuntary admission. In *Zinermon v. Burch* (1990), the Court ruled that individuals who are seriously mentally ill are not able to consent to a voluntary admission and therefore must be involuntarily committed. Research also has shown that though legal status (voluntary versus involuntary) is related to perception of coercion, there are important differences between being involuntarily committed and feeling coerced (Hiday, Swartz, Swanson, & Wagner, 1997; Hoge et al., 1997; Nicholson, Ekenstam, & Norwood, 1996). As a result, research has begun to ignore the distinction between voluntary and involuntary and focus more on the level of **coercion** the patient experiences or perceives they experience.

The Impact of Coercion on Civil Commitment

One fear is that undue coercion will lead to poor therapeutic relationships between clinicians and patients and thereby treatment effectiveness will be reduced and readmissions increased. Others suggest that many patients may only be thankful for care because they were coerced (Gardner & Lidz, 2001). However, 81% of clinicians believed that mandated community outpatient treatment deters people with schizophrenia from seeking voluntary treatment and 78% believed that legal pressures encouraged patients to stay in treatment. Furthermore, 36% of patients admitted that fear of coercive treatment reduced their chances of seeking mental health assistance and fear of coerced treatment was correlated with concerns about seeking treatment (Swartz, Swanson, & Hannon, 2003). Results suggest that coercive treatment is a barrier to patients seeking treatment and that clinicians may minimize the relationship between coercion and seeking treatment.

Until recently, there has been little research examining the role of coercion in civil commitment decisions. This literature has largely focused on reducing any potential harm to the patient by eliminating or reducing the perception that the civil commitment process is coercive (McKenna, Simpson, & Coverdale, 2000). For example, Huss and Zeiss (2005) examined whether or not more fully explaining to patients that they had the right to a commitment hearing as well as the right to avoid a commitment hearing reduced direct and indirect procedural indicators of coercion. These results were largely supportive of a reduction in coercion and better treatment outcome. Initially, efforts were aimed at defining and assessing coercions among psychiatric patients (Bennett et al., 1993, Gardner et al., 1993, Hoge et al., 1993). Though coercion has been measured in different ways, a standardized interview and measure do exist. The MacArthur Admission Experience

Interview and the MacArthur Admission Experience Survey (Gardner et al., 1993) and several coercion-related behaviors have routinely been used: persuasion, inducement, threat, show of force, physical force, legal force, asked for a dispositional preference, giving an order, and deception (Lidz et al., 1997).

One question in the literature is whether patients change their original attitudes toward hospitalization during the hospitalization. Some have justified inpatient commitment on the theory that many patients change their mind about being hospitalized and are eventually grateful after receiving treatment. Gardner et al. (1999) interviewed 433 admitted patients at two different psychiatric hospitals. Results showed that the majority of patients believed they needed to be hospitalized (76%) and that over half (52%) of the patients who originally denied needing hospitalization later changed their minds. Patients who changed their minds did not differ from those who did not change their minds according to race, sex, age, anger about being hospitalized upon admission, or severity of mental illness. However, change was related to believing one had a mental illness. Patients who believed they had a mental illness upon admission were more likely to change their mind.

Sources and Frequency of Coercion

Studies also have examined the sources of coercive behaviors among patients. One study found that mental health professionals were the most important source of coercion and that they exhibit several different types of coercion (Lidz et al., 2000). In fact, "it is the clinical pressures, not the behaviors of relatives, friends, or law enforcement personnel, that appear to account for patients' perceptions that they have been coerced" (p. 79). Furthermore, though patients, staff, and family/friends may share a common conceptualization of coercion in the admission process, patients' perceptions do not necessarily match staff perceptions of coercion (Hoge et al., 1998). Family members were less likely to report coercion and negative pressures related to the admission process (Hoge et al., 1998). Clinicians and patients also disagree on the level of coercion involved in issues such as forced medication, the involuntary nature of earlier commitments, and current legal status (Poulsen & Engberg, 2001). In general, there appears to be a "grey zone" (p. 60) between what patients and clinicians believe is coercive (Poulsen & Engberg, 2001). Patients' overall level of coercion is tied to a perception of the procedural justice involved in a situation. **Procedural justice** refers to the notion that an individual has been treated fairly in a given context, regardless of the outcome (Tyler, 2006). Patients who feel like they are not listened to or given a role in the process tend to report higher levels of coercion (Lidz et al., 1995), whereas clinicians' and family members' perceptions of coercion are not strongly related to issues involving procedural justice (Hoge, Lidz, et al., 1997; as cited in Lidz et al., 1997). In addition, further research has found that at times race (African Americans felt less coerced), factors related to negative symbolic pressure (e.g., threats, giving orders, deception, show of force), and force (legal and physical force) are related to perceived coercion in commitment patients. Additional analyses did not find race consistently related to coercion, though (Lidz et al., 1998).

The problem with much of the coercion research has been that it relies on patient reports. Patient reports can be potentially fallible both because of their position in the process and because their mental health issues may skew their perspective. Reports attempting a more comprehensive examination have found that there is not a single source of data that is completely adequate, even though patient reports appear to be the most accurate (Lidz et al., 1997). The one exception to this finding was in regard to the use of force in which clinicians appear to be the most accurate sources of information. Moreover, the discrepancy between patient reports of coercion and other sources does not appear to be related to mental illness or severity of mental illness on a consistent basis (Lidz et al., 1997).

One question remains: how frequent is coercion? In general, persuasion is the most common method of coercion occurring in 61.6% of patients. The only other aspect of coercion that occurs in a majority of commitment patients was whether anyone asked about the patient's preference for hospital admission (56.8%), followed by legal force (33.1%), giving orders (28.5%), show of force (22.8%), threats (18.6%), inducement (8.8%), deception (6.4%), and physical force (5.8%) (Lidz et al., 1998). Other research has found that while 70% of psychiatric patients believe their admissions were necessary, 74% felt they were under pressure to be hospitalized (Bonsack & Borgeat, 2005).

One way to prevent coercion is by following admission criteria and not allowing outside biases to enter the decision process. A positive finding along those lines is that clinicians appear to rely only on the commitment criteria (mental illness, dangerousness, and need for treatment) to retain individuals for civil commitment (Segal, Laurie, & Segal, 2001). Other factors such as the difficulty of the setting, patient's lack of insurance, patient's involuntary admission status, patient's level of participation in evaluation process, gender, and race do not relate to retention for civil commitment. However, the greater the workload experienced by the evaluating clinician, the more likely he or she is to retain a patient (Segal et al., 2001).

Right to Make Treatment Decisions and Refuse Treatment

Another issue related to coercion during the commitment process is the right to make treatment-related decisions and refuse treatment. It has been argued that one way to make the treatment process less coercive is to involve patients in the treatment decision process. It is clear that individuals who have been civilly committed have a right to receive treatment. In *Wyatt v. Stickney* (1972), an Alabama law allowed for the commitment of individuals for "safe keeping." Originally, the plaintiffs sued the state of Alabama over cutbacks at the state mental hospital because of a budget shortfall. The plaintiffs happened to include Ricky Wyatt, a 15-year-old relative of a former employee at the Bryce State Mental Hospital, as a plaintiff. Though the Alabama courts ruled the state had a right to lay off staff, additional consideration was given to the treatment of Ricky Wyatt. Wyatt had been institutionalized, despite the lack of a mental illness, simply because he was identified as a juvenile delinquent. The suit charged that the conditions were horrible and treatment was only used to manage the behavior of the patients.

Ultimately, the courts determined patients had a right to treatment that would give them a realistic opportunity to improve their mental condition. Although the right to treatment was limited in later decisions (*O'Connor v. Donaldson*, 1975; *Youngberg v. Romeo*, 1982), patients who have been involuntarily committed have basic rights regarding treatment.

The United States Supreme Court also addressed the right to refuse treatment on several occasions. On each occasion the Court recognized the right to refuse treatment but also recognized that the state often has legitimate interests in forced treatment. *Sell v. United States* (2003) held that a defendant who was hospitalized after being found incompetent to stand trial may be involuntarily medicated in some circumstances. Charles Sell was a practicing dentist with an extensive history of mental illness. He was charged with fraud and attempted murder. He was ultimately diagnosed with delusional disorder because he displayed paranoid delusions and other psychotic behaviors. As a result, prison staff recommended he take antipsychotic medication, which he refused. The Court stated that a defendant had the right to refuse medication and exercise his or her own autonomy, especially when that treatment can be mind altering and invasive. The Court also took into account the right of the state to arrive at a disposition for a criminal charge or charges. The Supreme Court has continually upheld the state's right to forcibly medicate individuals (*Riggins v. Nevada*, 1992; *Washington v. Harper*, 1990). They relied on these past cases in *Sell* and ultimately concluded that the government can involuntarily medicate a defendant if the treatment is medically appropriate and is unlikely to have side effects that reduce the fairness of the trial, if less intrusive methods are considered, and if it is important to governmental interests (*Sell v. United States*, 2003).

Competency to Make Treatment Decisions

"As commitment statutes are currently written and interpreted, commitment neither requires a determination of incompetence nor provides a legal basis for treating the individual as incompetent, and many commitment statutes contain provisions explicitly rejecting an inference of incompetence from commitment" (Schopp, 2001, p. 109). As a result, civilly committed individuals still have the right to make treatment decisions. Although seriously mentally ill individuals may be unable to give voluntary consent for admission, involuntarily committed individuals are still allowed to make treatment decisions because their involuntary status affords them protection of their due process rights (*Zinermon v. Burch*, 1990). The MacArthur Competence Assessment Tool for Treatment (MacCAT-T) is a measure specifically designed to assess competency to give informed consent and make treatment decisions (Grisso & Appelbaum, 1998). Research findings also clearly indicate that the majority of the mentally ill are competent to make treatment decisions (Grisso & Appelbaum, 1995). Grisso and Appelbaum (1995) found that almost 50% of the patients with schizophrenia and 76% of the depressed patient group performed in the adequate range of the MacCAT-T and that only a very few patients would continue to be incompetent to make these decisions after follow-up explanations. Another study found no differences between

patients suffering from schizophrenia, schizoaffective disorder, and bipolar disorder (Howe et al., 2005).

Mental Health Advanced Directives

The case of Terri Schiavo helped bring attention to medical decision making and advanced directives. At 26, Mrs. Schiavo collapsed at her home due to respiratory and cardiac arrest. She fell into a coma and later lapsed into a persistent vegetative state. Her physical and mental state were the focus of a lengthy court battle that made national news after her husband petitioned the state to remove her feeding tube and Mrs. Schiavo's parents disagreed with his removal decision. Both parties maintained that Mrs. Schiavo would choose their particular course of action if she was able to communicate her needs. Mrs. Schiavo was not able to communicate her needs and she had not drafted any legal documents such as a living will or an advanced directive to voice her opinion should she ever experience the circumstances she was now suffering. Mental health advance directives are similar to documents such as living wills, often used in situations such as Mrs. Schiavo's but are relevant for making mental health decisions. Mental health or psychiatric advance directives identify treatment preferences if someone becomes incompetent or is unable to communicate his or her preferences for treatment of their mental health needs. Mental health advanced directives allow the person to make any treatment decisions before they become incapacitated, instead of a friend, family member, or treatment staff having to do so. A person must be competent when he or she originally makes the directive and must clearly identify his or her preferences, and health care providers must be told of the directives in order to comply with them.

Advance directives are especially important for individuals who have a history of alternating periods of competence and incompetence (Appelbaum, 2004). These patients are both the most vulnerable to coercion and the most in need of care (Keefe & Pinals, 2004). Every state in the United States has authorized the use of some form of mental health care directive, either as part of legislation authorizing advance health care directives or specific statutes on mental health advance directives (Srebnik & La Fond, 1999). However, mental health directives are not well known by hospital staff or patients. Research suggests that only 4% to 13% of psychiatric patients signed an advance directive (Swanson, Swartz, Ferron, Elbogen, & Van Dorn, 2006). Clinicians have expressed reservations about implementing advance directives they see as potentially amounting to refusals of care (Swanson et al., 2003b). However, clinicians who are educated about the legal parameters of advance directives appear to be much more accepting of them (Elbogen et al., 2005) and upward of 77% of patients would complete an advance directive if given assistance to do so (Swanson et al., 2006). Mental health advance directives appear to be a mechanism to reduce coercion among psychiatric patients, especially those most vulnerable. One intervention, Facilitated Psychiatric Advanced Directives (F-PAD), has even been designed to encourage the use of advanced directives. F-PAD appears to give psychiatric patients more control over their own

treatment during mental health crises by reducing the probability of coercive interventions such as being picked up by police, being placed in handcuffs, being involuntarily committed to a hospital, being placed in seclusion in a locked hospital room, being placed in physical restraints, and being forcibly medicated (Swanson et al., 2008).

Practice of Civil Commitment

The clinical practice involved in civil commitment tends to be somewhat similar to traditional clinical practice with the added emphasis on assessing for dangerousness as a central component. A forensic psychologist working with civil committees will assess for dangerousness to self or others, diagnose mental illness, and apply traditional and current methods of treatment to the mentally ill. However, these routine tasks are still performed in a legal context with additional ramifications for the patient and the family along with some subtle nuances not routinely faced in clinical practice. Furthermore, the same scope of practice issues that apply to diagnosing mental illness or assessing risk also apply to civil commitment. Given the relative lack of research in this area and the frequent lack of information in these instances to make these determinations, it is especially important for the forensic psychologist to be aware of the research basis for any process or conclusion.

Assessment and Treatment of Committed Patients

We discussed forensic assessment in Chapter 2 and those same general principles apply to assessment of mental illness in the context of a civil commitment. Any assessment should be comprehensive and look for converging evidence from a variety of potential psychological measures (personality, cognitive, neuropsychological) and collateral information, while still keeping in mind that malingering should be considered. One issue relevant to the assessment of mental illness is whether the definition of mental illness is appropriate. As discussed earlier in this chapter, the legal definition of mental illness is not always identical to the psychological definition. Although mental illness is not generally well defined (*Foucha v. Louisiana*, 1992), most legal definitions of mental illness include the more severe mental illnesses such as psychosis (e.g., schizophrenia), mood disorders (e.g., depression or bipolar disorder), or cognitive disorders (e.g., dementia) (Stafford, 2002).

In addition to assessment, treatment is an integral part of the civil commitment process once individuals have been civilly committed. Our previous review of the outpatient literature suggests that outpatient commitment is effective, compared to traditional inpatient hospitalization. However, there are very few studies that have examined whether civilly committed patients fare better than those who have not been civilly committed (Hiday, 1988). The lack of research is probably because inpatient treatment is becoming a less favorable option, but also because of the criminalization of the mentally ill, the short duration of hospitalizations, and the chronic nature of those typically hospitalized. Mahler and Co (1984) found that 68% of the

noncommitted patients and 55% of the committed patients were readmitted during a 22-month follow-up period. Shore, Breakey, and Arvidson (1981) also found that 6 months later, patients who had been committed were more improved than those who had not been treated.

Assessment of Danger to Self

To this point, we have not discussed the clinical aspects of assessing danger to self or suicidal ideation. Assessing for the risk of suicide is a difficult clinical task and it suffers from some of the same problems as violence risk assessment that we reviewed in Chapter 5. For example, the base rate for suicide is generally low and the accuracy of predictions poor (Pokorny, 1983). However, there is significant information available regarding the risk factors and base rates for suicide attempts and completions. Clinicians rate a history of suicide attempts, suicidal thoughts, severe hopelessness, an attraction to death, family history of suicide, acute abuse of alcohol, and loss or separation as the most critical risk factors for completed suicide (Peruzzi & Bongar, 1999). These perceptions are similar to those risk factors commonly identified in the literature as the most important to long-term predictions of suicide: past suicidal gestures or attempts, suicidal thoughts, hopelessness, male gender, multiple psychiatric hospitalizations, and extended duration of hospitalizations (Cassells, Paterson, Dowding, & Morrison, 2005). Factors such as clinical improvement, insight, substance abuse, medication noncompliance, and loss of social support are risk factors for short-term predictions of suicide (Cassells et al., 2005). The presence of dependents and meaningful daily routines act as protective factors (Appleby, 1992; De Hart, McKenzie, & Peuskens, 2001). In addition to identifying the presence of risk and protective factors, there are measures available for the assessment of suicide risk (Rothberg & Geer-Williams, 1992). However, these scales are likely to best serve as structured guides instead of measures with definitive cutoffs (Stafford, 2002).

Whether it is included in danger to self or separated in local mental health statutes, grave disability is another important aspect of civil commitment evaluations. Because grave disability requires a person be unable to meet basic needs, some suggest that procedures used to assess competency to consent to treatment should be used to make these determinations (Stafford, 2002). Instruments like the MacCAT-T and the Independent Living Scales are often recommended to assist in making these determinations as part of a comprehensive evaluation (Stafford, 2002).

Assessment of Danger to Others

Since the risk assessment literature was reviewed in Chapter 5, an extensive examination of the available information is beyond the scope of this section. However, one issue especially relevant to the assessment of danger to others in civil commitments is the relationship between mental illness and violence. The identification of mental illness as a risk factor may encourage public concern and feed public stereotypes that all mentally ill people are violent (Paterson, 2006) and that people should be concerned if a neighbor

suffers from a mental illness or a halfway house for the mentally ill is established in their neighborhood. Generally, the relationship between mental illness and violence has been inconsistent (Ferris et al., 1997). Moreover, the vast majority of mentally ill people will not become violent and are even more likely to be victims of violence than to be perpetrators of violence (Teplin, McClelland, Abram, & Weiner, 2005).

However, the research has become more consistent in establishing a relationship between mental illness and violence. Although the overwhelming majority of the mentally ill are never violent (Link, Monahan, Stueve, & Cullen, 1999), individuals who suffer from mental illness are more likely to be violent over their lifetime than people who do not suffer from mental illness (Borum, 1996). However, this is a very complex relationship and not a strong one (Monahan & Arnold, 1996). First, it is not true that anyone with mental illness is at greater risk for future violence. For example, there is no evidence that people who suffer from disorders such as generalized anxiety disorder, frotteurism, or trichotillomania are at greater risk for violence. However, there is evidence that individuals with certain mental illnesses like schizophrenia and bipolar disorder are at greater risk for violence (Swanson, 1994). Moreover, even if people with schizophrenia are at greater risk for violence it is not simply the diagnosis of schizophrenia but also the presence of certain symptoms that increases their risk. For example, research suggests that certain psychotic symptoms called threat/control-override (TCO) delusions may be linked to violence (Link & Stueve, 1994), though the research has not been totally consistent. TCOs are delusional symptoms in which individuals believe they are being threatened or that they are being controlled by an outside entity. Although symptoms of particular mental illnesses increase the risk for violence, the risk is not simply the result of mental illness or of certain symptoms but more so because of the co-occurrence of substance abuse (Swanson, 1994). The relationship between mental illness and violence is weak (Monahan & Arnold, 1996), but the additional presence of alcohol or drug abuse increase risk several fold (Swanson, 1994). Although there appears to be at least a weak link between mental illness and violence, stereotypes that contribute to the public belief that mentally ill individuals are dramatically more likely to perpetrate violence are not realistic and unsupported by a current review of the research.

There are other important considerations in the context of civil commitment. Dangerousness determinations require behavioral evidence of risk (*Lessard v. Schmidt*, 1972). As a result, some have argued that the use of actuarial and structured approaches are not necessary (Strachan, 2008). These risk assessments are not just predictions of future dangerousness but a description of the risk that will allow the fact finder to make the legal determination. In addition, most jurisdictions focus on the current harm not the future harm. As a result risk assessments in regard to civil commitment are not necessarily as future oriented as many of the situations described in Chapter 5. Finally, remember that the dangerousness and the mental illness must be associated with one another in order to meet criteria for civil commitment. The person must be dangerousness because of the mental illness. The logic would be that the person needs to be hospitalized in order to treat the mental illness and decrease risk.

Reflection and Review

1. What are the implications for basing civil commitment law in parens patriae instead of police power?
2. Does civil commitment fulfill its goals?
3. What are the risks in requiring only a mental illness or dangerousness as requirements for civil commitment?
4. Does one form of civil commitment seem superior to the others?
5. How can coercion impact the practice of civil commitment?

Key Terms

coercion
conditional release
deinstitutionalization
emergency commitment
extended commitment
grave disability
parens patriae
police power
preventative commitment
procedural justice
traditional outpatient commitment

Further Readings

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8 Criminal and Civil Competence

Chapter Objectives

1. Be able to describe competency
2. Describe the major legal cases focusing on competency
3. Discuss the difficulties of practicing in this forensic area
4. Identify the different civil competencies

Competency is something very fundamental to the law because it refers to an individual's general ability to exercise decisions and understand the nature of legal proceedings. Above all, it is based on the need for fairness in our legal system. A legal proceeding in which someone lacks the mental state sufficient to participate and understand the issues is inherently unfair. Because legal proceedings are comprised of numerous minor and major decision points, competency can be an issue throughout both criminal and civil proceedings. Issues of competency can arise in relation to an individual's ability to confess, stand trial, or even be executed in criminal proceedings. Civil competency can relate to one's ability to parent a child, serve as a witness, or make medical decisions. A person failing to exhibit sufficient competency to make decisions may be both banned from participating in certain aspects of the legal system and forced to participate in additional proceedings to prove his competence. Because a thorough examination of all the different legal contexts in which competency frequently arises is beyond the scope of this chapter, we will focus largely on criminal competence with an emphasis on competency to stand trial. However, we will briefly identify some areas of civil competency at the end of the chapter to give you a flavor of the significant differences involved in the two areas.

As with the other issues we have discussed, keep in mind that the impact of the law and scope of practice issues continue to play a prominent role in evaluations of

competence. The idea that the law can have a significant impact on forensic practice should be clear in Grisso's (2003a) notion that all legal competencies involve some fundamental components: (1) they acknowledge the right to make decisions that can impact one's life; (2) they acknowledge that some may not have the capacity to make these decisions and that these inabilities may endanger them or others around them; (3) they provide a legal procedure for determining these inabilities; and (4) determination of these limitations justifies the state's intrusion to protect the individual by limiting some of his or her rights. Given that the courts may limit an individual's rights and the research findings that courts may defer to experts' opinions, the importance of forensic psychologists practicing only in those areas in which they are qualified is increasingly important.

Raising the Issue of Competency in Criminal Proceedings

As suggested before, competency is an issue throughout the criminal process. Criminally related competency is frequently referred to as adjudicative competency or as fitness in some jurisdictions. A defendant must be competent to confess, plead, stand trial, waive the right to an attorney, refuse the insanity defense, be sentenced, and be executed. In each of these instances, the focus is on the defendant's present mental state at any given instance along the criminal process. Our legal system requires that a person understand the nature and the purpose of the criminal proceedings in order to ensure that the adversarial process is fair. In the United States, this belief is rooted in the Sixth Amendment of the Constitution. The Sixth Amendment requires that a person is informed of the nature of any accusation, has a right to confront any witnesses against him, and has the right to the assistance of counsel in his defense. Unlike insanity, competency is a common issue in criminal trials and may be the most frequently occurring mental health question in criminal law.

Competency to Stand Trial (CST)

Our discussion of competency will begin by focusing not only on criminal competency but more precisely on competency to stand trial (CST). Competency to stand trial is the most prominent and frequently examined aspect of criminal competency. Some argue that CST should serve as a "blueprint" for research and practice in other competency areas that have been less frequently examined (Zapf, Viljoen, Whittemore, Poythress, & Roesch, 2002, p. 171). Moreover, legal rulings have suggested that the legal standard for competency to stand trial should be equated with other instances in which competency arises (*Godinez v. Moran*, 1993; *Regina v. Whittle*, 1994).

There is a long history in English common law of stopping legal proceedings because defendants were incompetent to stand trial. Stafford (2003) states that this notion traces back further to the prohibition against trials **in absentia**. A defendant could not be absent from his own trial (i.e., in absentia). This practice evolved from the need to

be physically present for one's trial into the requirement to be mentally present at the time of trial. Statutes and case law have continued to refine these early notions that emphasized the competence of a defendant in order to ensure the fairness and accuracy of the legal proceedings. The Canadian standard for competency, or **fitness** as it is frequently termed, defines someone who is unfit to stand trial as someone who is unable to understand or object to the nature of the proceedings, unable to understand the consequences of the proceedings, or communicate with counsel. However, the Canadian standard specifically requires the inabilities be the result of a mental disorder. The dominant standard in the United States is based on the Supreme Court ruling in *Dusky v. United States* (1960). *Dusky* required that a defendant exhibit "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him" (p. 402). It does not specifically require a mental illness (Cruise & Rogers, 1998), though most defendants found incompetent suffer from severe mental illness. Competency has been further defined by the federal courts (*Wieter v. Settle*, 1961) and by specific states (e.g., *State v. Guatney*, 1980). The notions of competency in the United States and Canada are similar, but the U.S. standard tends to result in a higher threshold for competency (Zapf & Roesch, 2001).

Prevalence of CST

Estimates suggest that as many as 60,000 competency evaluations take place each year in the United States (Bonnie & Grisso, 2000) and that this figure has consistently risen from 25,000 over three decades ago (Steadman, Monahan, Harstone, Davis, & Robbins, 1982). Estimates vary, but pretrial competency evaluations appear to occur in 2% to 8% of all felony cases (Hoge, Bonnie, Poythress, & Monahan, 1992). Attorneys further have doubts about their client's competence in as many as 15% of all felony cases, with less frequent doubts in misdemeanor cases (Hoge, Lidz et al., 1997), but they only obtain competency evaluations in half of these instances (Poythress, Bonnie, Hoge, Monahan, & Oberlander, 1994). Attorneys routinely refer to the low threshold for competence (i.e., it is easy to be found competent, difficult to be found incompetent) as one of the reasons for not obtaining more competency evaluations and often cite client passivity and rejection of the attorney's advice as reasons for originally doubting competency (Hoge et al., 1992; Poythress et al., 1994). Ultimately, only about 20% of defendants referred for competency evaluations are deemed incompetent (Zapf et al., 2006). CST evaluations are the most frequently occurring forensic evaluation in the legal system (Warren et al., 2006), and more money is spent on the evaluation, adjudication, and treatment of people with suspected competency issues than any other forensic issue (Golding, 1992b). For example, in 2012, an airline pilot for JetBlue began acting erratically midflight by running through the cabin yelling about Jesus and al-Qaida and had to be subdued by the passengers and crew. He was later found competent to stand trial but eventually determined to be Not Guilty by Reason of Insanity.

Procedures in CST

Though procedures vary from jurisdiction to jurisdiction, there are some generally universal procedures involved in CST evaluations. A defendant is legally presumed to be competent unless an issue of competency is raised (Bullock, 2003). Anyone can raise the issue of competency, but normally it is the defense attorney who raises the issue because it is in the best interests of the defendant. However, the trial judge is obligated to raise the issue if there is any doubt about the defendant's competency (*Pate v. Robinson*, 1966). This determination can be based on irrational behavior, demeanor at trial, or expert opinion (*Drope v. Missouri*, 1975). Wulach (1980) identified several reasons for ensuring competency. First, a competent defendant increases the accuracy of the trial because the defendant is able to communicate the facts of the case. Second, in order to ensure fairness and the defendant's due process, the defendant must be allowed to exercise his full rights. Third, the integrity of the process can be questioned for legal as well as moral reasons if incompetent defendants are tried. Fourth, the purpose of punishment is not upheld if a defendant is convicted and does not understand the meaning or intent of the punishment. In addition to these intentional reasons for ensuring the competency of the defendant, some commentators argue that competency is increasingly being used for trial strategy purposes. For example, a competency issue may be raised to avoid a trial or avoid a legal sanction and instead have the defendant committed to a mental health hospital instead of serving prison time (Slovenko, 1995).

Once a competency evaluation is identified as necessary and the evaluation is completed, a report is submitted to the court. At this point, a hearing may be scheduled to further examine the findings of the report and allow the forensic psychologist who conducted the evaluation to testify. However, these hearings are normally very brief and they rarely occur (Zapf et al., 2006). In most instances, all the involved parties conceded to the findings of the report.

If the parties stipulate the defendant is competent, the process continues toward trial. If the defendant is incompetent, there are several possible outcomes. The trial may be delayed until the defendant's competency is restored. Restoration may take place through a variety of psychiatric, psychological, and psychoeducational approaches that will be described later. However, there are limits on the amount of time a defendant can be held while awaiting restoration of competency. In *Jackson v. Indiana* (1972) the United States Supreme Court ruled that a defendant can only be institutionalized for a reasonable period of time to determine if the defendant can be restored to competency in the foreseeable future (Box 8.1). If the defendant is not institutionalized in order to restore competency, the charges can be dismissed with the option that the prosecution may file them again in the future. In either case, the defendant also may face civil commitment, whether it is eventually determined that they cannot be restored to competency in the foreseeable future or if the charges are to be dismissed.

The civil commitment of incompetent individuals, however, is controversial. Remember, civil commitment is a civil process and one in which a person is deprived of his individual liberty, something typically reserved for the criminal law. The concern has

Box 8.1. Importance of *Jackson v. Indiana* (1972)

Jackson v. Indiana (1972) is a Supreme Court case that clearly intended to improve the outcome associated with the institutionalization of incompetent defendants. Prior to *Jackson*, defendants who had been found incompetent to stand trial could be held indefinitely no matter how trivial their alleged crime. Theon Jackson was a 27-year-old deaf mute who could not read or write and had almost no ability to communicate. He was originally charged with two purse snatchings in 1968 that totaled about $9 worth of property. Prior to trial he was evaluated by two different mental health experts and found to be incompetent to stand trial because his mental retardation and inability to communicate would make him unable to understand the nature of the proceedings or participate in his defense. Because his disabilities were not treatable, this finding amounted to a life sentence for Jackson. This practice was not uncommon at the time, as many incompetent defendants were confined to state hospitals for years and were more likely to die in the facility than to be ever released.

However, the purpose of competency was to ensure fairness and it did not seem fair to hand a man a life sentence for stealing two purses. As a result, the United States Supreme Court held that Jackson's due process rights were violated because of the failure to obtain a speedy trial and his continued incarceration without any criminal charges or conviction against him. The Court ordered that he either had to be released or civilly committed after he was held for a reasonable period of time. The Court did not further define a reasonable period of time, but it has often been equated with the amount of time a defendant would otherwise serve if convicted of the original crime.

been that individuals who are found incompetent and cannot be restored to competence are simply civilly committed until they are fit to continue to the adjudication process because of the legal charges against them. Levitt et al. (2010) investigated just that question in a large metropolitan city. Levitt et al. compared 293 not competent and not restorable defendants (NCNR) to 280 matched controls voluntarily admitted to the same psychiatric hospital. The NCNR group was less likely to meet admission criteria (e.g., suicidality, violence, threatening, delusions, and disability criteria), received court-ordered treatment more often, and had longer hospital stays despite being less dangerous to themselves or others. As a result, they concluded individuals found incompetent may be civilly committed in order to obtain additional confinement in certain high-profile cases, and therefore these individuals' rights under *Jackson* were being violated. Others have commented on similar results in different jurisdictions and point to the increasing levels of the mentally ill in the criminal justice system as the likely reason (Fisher & Grisso, 2010; Hoge, 2010).

Competency Evaluations

At the heart of the legal process is the competency evaluation itself. There appears to be significant agreement between the judge's final determination of competency and

the expert's evaluation (Zapf, Hubbard, Cooper, Wheeles, & Ronan, 2004). Gowensmith, Murrie, and Boccaccini (2012) even found in a large sample of reports from Hawaii that in 71% of the initial evaluations, all three independent evaluators gave at least a moderate level of agreement. However, there is no standard approach for conducting competency evaluations and there appears to be a great deal of variability. Borum and Grisso (1995) surveyed forensic psychologists and psychiatrists regarding their standard practice in conducting competence to stand trial evaluations. They found that forensic psychologists were evenly split on the importance of using psychological testing with 51% seeing testing as essential and 49% viewing it as optional. These forensic psychologists also mentioned they used objective measures of personality (90%), neuropsychological testing (42%), competency instruments (36%), and projective tests (33%). Heilbrun and Collins (1995) examined the CST reports themselves to assess standard practice in these evaluations. They found that 15.3% of the reports included mention of psychological testing with the MMPI and the Wechsler Adult Intelligence Scale-Revised (WAIS-R) as the most frequently used. Lally (2003) found that among forensic psychologists with greater expertise, 62% recommended use of the current version of the WAIS and 56% recommended a specific forensic measure of competency (e.g., MacArthur Competence Assessment Tool-Criminal Adjudication; MacCAT-CA).

One study asked whether certain forensic psychologists were more likely than others to find defendants incompetent. Researchers found that rates of finding a defendant incompetent varied from 0% to 62% (Murrie, Boccaccini, Zapf, Warren, & Henderson, 2008). They speculated that the defendant's diagnosis (i.e., psychosis), outpatient versus inpatient settings as the referral source, characteristics of the particular mental health and legal system, and evaluator characteristics such as professional training and profession accounted for these differences. For example, they found that social workers were most likely to find a defendant incompetent, followed by psychologists, with psychiatrists the least likely to find a defendant incompetent.

Nicholson and Norwood (2000) reviewed the available studies and found the percentage of experts who reported using a different method varied 85% to 100% reporting use of a clinical interview, 45% to 93% a mental status exam, 9% to 69% psychological tests, and 0% to 25% competency specific forensic instruments (see Table 8.1). Although the composition of the samples and whether forensic psychiatrists were included with the forensic psychologists (psychiatrists are not typically trained in the administration of

Table 8.1. Frequency of Use in Competency Evaluations

Method	Percentage used
Clinical interview	85–100
Mental status exam	45–93
Psychological tests	9–69
Review of collateral information	0–96
Competency specific tests	0–25

Source: Data from Nicholson & Norwood (2000)

psychological tests) might be a plausible explanation for the reduced rates of test usage, Nicholson and Norwood (2000) concluded that it did not explain all the variability. Rates also varied across studies examining review of collateral information with anywhere from 0% to 96% of the experts using review of records (Nicholson & Norwood, 2000). They generally concluded that there does not appear to be a consistent standard of practice among forensic psychologists conducting CST evaluations.

Forensic Assessment Instruments for Competency

There are over half a dozen forensic assessment instruments (FAI) designed to assess competency to stand trial (Zapf & Viljoen, 2003). Furthermore, even though specialized tests are not used in the majority of competency evaluations, the continued development of these measures marks an important step forward in the development of standardized competency evaluations (Zapf et al., 2002). The available instruments reflect a range of methods from self-report questionnaires to interview-based instruments. The use of standardized forensic instruments specifically focused on competency to stand trial is in keeping with current trends in the field of forensic psychology.

The first two attempts at a systematic measure to assess competency were the Competency Screening Test (CST; Lipsitt, Lelos, & McGarry, 1971) and the Competency to Stand Trial Assessment Instrument (CAI; McGarry, 1973). The CAI is a 13-item measure that identifies 13 functions related to competency that can be assessed through two or three interview questions. It has been largely criticized for a lack of norms and scoring criteria and some of the assumptions it is based upon (Cruise & Rogers, 1998). The CST is a 22-item sentence completion questionnaire that was developed as a screening instrument and consists of items such as, "If the jury finds me guilty, I __." Each item is scored according to the level of competency exhibited in the response (0 for an incompetent response, 1 for a fairly competent response, and 2 for a competent response). The instrument exhibits good reliability but high false positive rates, as it tends to classify a number of people as incompetent who are competent (Nicholson, Robertson, Johnson, & Jensen, 1988). As a result, the measure has been largely unstudied over the past decade (Stafford, 2003).

Another measure of competency that has been developed and revised from its original version is the Georgia Court Competency Test-Mississippi Version Revised (GCCT-MSH). The GCCT originally included 17 items that focused on courtroom and legal practices, current charges and likely consequences, and the defendant's relationship with his attorney (Wildman et al., 1978). The GCCT was revised and now includes 21 items devised to screen out defendants who are clearly competent to stand trial. Defendants are asked to visually identify different aspects of the courtroom and then respond to a series of interview questions. Although the instrument exhibits good reliability and validity (Nicholson, Briggs, & Robertson, 1988), the GCCT and GCCT-MSH have been criticized because they focus on foundational competencies (e.g., the ability to communicate with one's attorney and the nature of the charges) instead of the decisional competences (i.e., overall cognitive ability) found in other competency measures (Zapf & Viljoen, 2003).

The Fitness Interview Test (FIT; Roesch, Webster, & Eaves, 1984) and the Fitness Interview Test-Revised (FIT-R; Roesch, Zapf, Eaves, & Webster, 1998) are structured interviews originally based on Canadian law, though the FIT-R was revised with U.S. federal standards in mind (Roesch, Zapf, & Eaves, 2006). They have been described as idiographic instruments because they focus on specific and contextual characteristics (Zapf & Roesch, 2009). The FIT-R consists of items designed to assess different psycholegal issues involved in competency. Questions are divided into specific areas: the ability to understand the nature of the proceedings, the ability to understand the potential consequences, and the ability to communicate with one's attorney. Research has supported the use of the FIT and FIT-R in terms of their reliability and validity (Viljoen, Roesch, & Zapf, 2002; Zapf & Roesch, 1997, 2001; Zapf, Roesch, & Viljoen, 2001).

The Evaluation of Competency to Stand Trial-Revised (ECST-R; Rogers, Tillbrook, & Sewell, 2004), based on the *Dusky* standard, was designed to assess not only CST but also other specific competencies. It is comprised of 18 items and four different scales: Factual Understanding of the Courtroom Proceedings, Rational Understanding of the Courtroom Proceedings, Consult with Counsel, and Overall Rational Ability. In addition, the ECST-R has 28 items on five different scales that are designed to screen for feigning of incompetency. The ECST-R has demonstrated good reliability and validity (Rogers et al. 2004; Vitacco, Rogers, Gabel, & Munizza, 2007).

The MacArthur Foundation Research Network developed two FAI instruments: the MacArthur Structured Assessment of the Competencies of Criminal Defendants (MacSAD-CD; Hoge, Bonnie et al., 1997) and the MacArthur Competence Assessment Tool-Criminal Adjudication (MacCAT-CA; Poythress et al., 1999). MacSAD-CD was originally developed to distinguish competent from incompetent defendants and to distinguish the dynamic nature of competency among distinct quantifiable domains (Hoge, Bonnie et al., 1997). Research found the MacSAD-CD was positively related to clinical judgments of competency and negatively related to psychopathology and cognitive deficits (Stafford, 2003). However, the MacSAD-CD was difficult to administer for clinical purposes and therefore the authors created a modified version, the MacCAT-CA. The MacCAT-CA emphasizes three different areas of competence: understanding, reasoning, and appreciation. Early indications are that the MacCAT-CA is sound in terms of its reliability and validity (Zapf, Skeem, & Golding, 2005). However, there are several items that utilize a hypothetical case vignette that may not apply directly to the vast majority of cases (Rogers, Grandjean, Tillbrook, Vitacco, & Sewell, 2001; Zapf et al., 2005). This aspect of the instrument would limit its generalizability. However, the MacCAT-CA is a tool and not a test of competency—meaning that the authors did not intend for it to result in an overall score suggesting the person was or was not competent, but rather that it would be an additional piece of data to be integrated into the overall evaluation of competency.

Research has consistently demonstrated that across different competency instruments, incompetent defendants perform more poorly (Hoge et al., 1996; Nicholson & Kugler, 1991). However, there are some special considerations in using these instruments. Because of the low threshold for finding a defendant competent, it is important to have instruments that allow experts to quickly screen out potential defendants who

clearly will meet the low threshold (Zapf & Viljoen, 2003). Although these measures allow for a standardized approach that is likely to lead to more reliable results, relying on a single measure without consideration of the contextual issues may hamper their use in individualized assessments of competency (Zapf & Viljoen, 2003). As a result, it would be inadvisable for a practicing forensic psychologist to simply base a decision of competence on a score on one of these single measures. Zapf and Roesch (2009) recommend electing a measure that can be used in every evaluation and use an additional measure that has the ability to compare the defendant to other defendants in a normative sample.

A comprehensive approach to competency evaluations

Beyond the use of specific measures of intelligence, psychopathology, or even specialized forensic instruments, is the consideration of a general approach to competency assessment. Many have argued that forensic psychologists often are misguided in their approach to addressing legal questions related to competency (Winick, 1995b). Grisso (1988) argues for the clear understanding of the legal notion of competency and where it diverges from related psychological constructs. He further identifies five objectives that allow for the translation of "the legal definition and procedure of competency to stand trial into objectives for competency evaluations" (Grisso, 1988, p. 11). Grisso (1988) argues that competency evaluations should include a *functional* description of specific abilities, a *causal* explanation for deficits in competency abilities, the *interactive* significance of deficits in competency abilities, *conclusory* opinions about legal competency and incompetency, and *prescriptive* remediation for deficits in competency abilities.

It is important to focus on the defendant's **functional abilities** by examining her strengths and weaknesses as they apply to the legal standard. Instead of a forensic psychologist focusing on general abilities such as intelligence and mental illness, the forensic psychologist should describe the relationship of these general abilities and their impact on a defendant's ability to communicate with an attorney, understand the legal proceedings, or describe the inability to do so during the trial because of any deficits. The *causal* objective encourages the forensic psychologist to explain the basis for any of the functional deficits previously identified. The basis for these deficits are normally mental illness but also may be related to a lack of awareness or low education about the legal process, or situational determinants like fatigue or malingering (Grisso, 1988). The *interactive* objective encourages an identification of the specific aspects of the trial that may impact the functional difficulties. This objective takes into consideration that two defendants with identical abilities may exhibit different levels of competency, given the nature of their different trials. One defendant may be on trial for a minor theft, facing only probation, and have a number of independent witnesses that will testify to guilt. Another defendant may be on trial for murder and only one witness able to describe the events of the murder. The level of stress involved for the murder defendant may cause his functioning to significantly deteriorate during his trial, while the other defendant will have little trouble. The interactive objective takes into account that different abilities may be required for different trials. Grisso (1988) encourages experts to make

a *conclusory* opinion or address the ultimate legal question in their evaluation, though he recognizes that other experts will disagree that such opinions should be offered and encourages individual experts to make the decision on their own. Finally, Grisso (1988) argues that the forensic psychologist should gather information that is relevant to the disposition of the defendant to offer *prescriptive* recommendations. Information that addresses the likelihood of the defendant responding to treatment and the best available programs will assist the court in determining the best option for a defendant. Even though the goal of the competency evaluation is not to determine whether the defendant needs treatment, addressing the best course of action to address any deficits does assist the court in adjudicating a defendant in the long run.

As previously noted, it is important to assess for malingering or feigning in any forensic evaluation and competence is no exception. It should also be noted that there is a distinction between feigning and malingering. Malingering refers to the production of false or exaggerated symptoms whereas feigning refers to the malingering of symptoms to appear a certain way. A person cannot technically malinger incompetency because it is not a psychiatric condition but a legal determination (Soliman & Resnick, 2010). Despite the low threshold for competency, the nature of the potential deficits (e.g., lack of understanding of legal concepts, unwillingness to communication with attorney) and the ability to delay a criminal conviction may encourage defendants awaiting trial to malinger. Currently, the degree to which defendants attempt to malinger on CST evaluations is not clear. Forensic psychologists have estimated that over 15% of their CST evaluations are colored by malingering (Rogers, Salekin, Sewell, Goldstein, & Leonard, 1998; Rogers, Sewell, & Goldstein, 1994). In one study, Gothard, Viglione, Meloy, and Sherman (1995) found that 12.7% of competency referrals were malingered. Research has even suggested that many of the previously reviewed competency measures are at risk for individuals feigning or malingering mental illness (Rogers, Sewell, Grandjean, & Vitacco, 2002). However, the Evaluation of Competency to Stand Trial-Revised (ECST-R) specifically assesses respondents' attempts to feign incompetency and has shown some success (Rogers, Jackson, Sewell, & Harrison, 2004; Rogers et al., 2002). A recent measure, the Interview of Legal Knowledge was specifically designed to assess feigning in competency evaluations, but it not a test of competence (Otto, Musick, & Sherrod, 2011). Whether a specific measure such as the ECST-R is used or not, an evaluation of malingering is an important aspect to any competency evaluation.

Characteristics of incompetent defendants

By identifying the characteristics of those defendants who are found to be incompetent or competent, we obtain some insight into those characteristics more likely to lead to a particular legal decision and the clinical decision-making process of the experts in the field, given the extremely high rate of agreement between expert opinions and the final legal decision (Zapf et al., 2004). Nicholson and Kugler's (1991) review identified a number of variables related to decisions of competence and incompetence. Since that time, more recent studies have further identified these characteristics. Cochrane, Grisso, and Frederick (2001) examined 1,710 federal defendants and found that 43% of those

receiving a psychotic diagnosis, 38% receiving an organic diagnosis, and 30% receiving a diagnosis of mental retardation were found to be incompetent to stand trial. Another study found that defendants suffering from a psychotic disorder were five times more likely to be found incompetent (Zapf et al., 2004). Another study continued this trend and also clearly found that although diagnoses such as psychosis were related to incompetence, the majority of psychotic defendants were found competent (Warren et al., 2006). A comprehensive meta-analysis looking at defendant characteristics found that "the most robust finding" (p. 1) was that defendants diagnosed with psychotic disorders were eight times more likely to be found incompetent (Pirelli, Gottdiener, & Zapf, 2011).

Concern has arisen since an early study of competency found that demographic variables (e.g., age, ethnicity) were better at predicting competency than clinical variables (e.g., current symptoms) (Rogers, Gillis, McMain, & Dickens, 1988). The concern arose because if demographic variables were key determiners of competency, it would be suggestive of bias. However, more recent research has not supported this early finding. Hart and Hare (1992) did not find any age or race bias and again identified psychosis as the biggest determinant of a finding of incompetence. Cooper and Zapf (2003) found that the employment status was the only demographic variable that predicted incompetence in 468 criminal defendants awaiting trial and referred for competency evaluations. Moreover, employment status is probably a variable related to mental illness in that mentally ill individuals are less likely to be employed. A recent study across 12 years and over 8,000 evaluations, however, found that older minority defendants were more likely to be identified as incompetent, though other factors were more important in determining competency (Warren et al., 2006). In a related study using vignettes and not actual competency evaluations, attorneys rated Spanish-speaking defendants as less mentally ill and were less likely to refer them for a CST evaluation, especially if they perceived logistical barriers to referring a client for an evaluation in their community (Varela, Boccaccini, Gonzalez, Gharagozloo, & Johnson, 2011). The Pirelli et al. (2011) meta-analysis did find non-white defendants, unemployed defendants, and unmarried defendants were more likely to be found incompetent. However, sex and previous competency evaluations were not significantly related to competency findings. An essential unresolved question is whether these variables are simply related to variables such as psychosis and may account for the significant relationship.

Although criminal charges are not a formal element in competency standards, many forensic psychologists encourage use of contextual elements in competency evaluations (Zapf et al., 2006). For example, Pirelli et al. (2011) found that defendants charged with violent crimes were more likely to be found incompetent. However, research has been inconsistent regarding contextual factors such as the alleged crime (see Warren et al., 2006). Nonetheless, even those studies that have found different rates of competence among defendants, depending on the severity of the charge, have found that the differences for crime severity disappear when controlling for other variables like mental illness (Cochrane et al., 2001; Cooper & Zapf, 2003). Even if defendants who commit more severe crimes are more likely to be found competent, these relationships are not as significant as the relationships for psychopathology in explaining final competency

decisions (Warren et al., 2006). These results suggest that crime severity is related to mental illness and that mental illness is the variable that is actually related to a finding of competence or incompetence.

Other Variables Related to Competence

There are other variables related to findings of competence. Studies have examined professional differences between forensic psychologists and forensic psychiatrists in conducting competence evaluations. Forensic psychologists are more likely to use collateral information, produce more clinical notes, and complete reports that are rated as more useful by legal professionals (Petrella & Poythress, 1983). Even though forensic psychologists and psychiatrists do not differ in their view of the importance of psychological testing, forensic psychologists are much more likely to use psychological testing in competency evaluations than forensic psychiatrists (Borum & Grisso, 1995). Warren et al. (2006) found that psychologists conduct more and longer interviews with defendants, spend more time preparing the competency evaluations, and were more likely to use psychological and neuropsychological testing. These findings are especially interesting given that trial judges and attorneys favored psychiatrists over psychologists in conducting evaluations for the court (Redding, Floyd, & Hawk, 2001). Results also suggest that psychologists may be more likely to find defendants incompetent than psychiatrists (Warren et al., 2006).

Another aspect of the competency evaluation that has been examined is the setting in which the evaluation took place (Warren, Rosenfeld, Fitch, & Hawk, 1997). Historically, competence evaluations have taken place in inpatient settings such as a mental health hospital. However, these evaluations are increasingly taking place on an outpatient basis (Grisso, Cocozza, Steadman, Greer, & Fisher, 1996). Such changes are largely cost-saving in nature but also may have important implications for the ultimate determination of competency. Although some research has not found any differences (Edens, Poythress, Nicholson, & Otto, 1999), other studies have found differences in competency evaluation across settings (Heilbrun & Collins, 1995; Warren et al., 1997, 2006). Heilbrun and Collins (1995) found that 47% of outpatient settings used psychological testing, while only 13% of inpatient settings used psychological testing. Warren et al. (2006) found that evaluations in inpatient settings involved more evaluators and more frequent clinical interviews but overall took less time than outpatient evaluations. There also were differences in the collateral information requested and collected as well as the type of testing utilized.

Scope of Practice in Competency Evaluations

As in the previous chapters, it is important to examine the limitations of clinical practice in regard to competency evaluations. You may believe that because competency is the most frequently addressed mental health issue and the threshold for competency is low there is little concern about the potential limitations. However, commentators have

argued that there are numerous problems with competency evaluations. For example, Bardwell and Arrigo (2002) argue that mental health professionals sometimes confuse competency and insanity and perform evaluations that attempt to address both issues simultaneously while misapplying the standards of each to the other. Skeem, Golding, Cohn, and Berge (1998) found that in 100 randomly selected competence to stand trial evaluations, evaluators rarely incorporated legally relevant information or addressed the reasoning underlying their psycholegal conclusions. Robinson and Acklin (2010) questioned the quality of reports based on an empirical examination of 150 CST reports. They described the reports as demonstrating "pervasive mediocrity with no respect for quality" (p. 131). However, they did express optimism in finding that those evaluators who were employed full time and produced the most reports submitted more quality reports and that after a training workshop the overall quality of the reports improved significantly. Mossman et al. (2010) did find that a sample of 156 competency reports "appeared to be very accurate" when evaluated with a new objective statistical approach.

Another concern is that because there is a high rate of agreement between mental health evaluations and judicial determinations of competency, a default legal decision is being made by the evaluating forensic psychologist. Winick (1995) has commented that the courts have simply delegated their decision-making capacity to mental health professionals and thereby obscured the differences between legal and clinical decisions. Agreement between opinions rendered by forensic psychologists and final judicial determinations are frequently estimated above 90%. One study only found a single departure in over 300 competency evaluations (Zapf et al., 2004). The 90% figure may even be an underestimate because the competency process is frequently not completed because criminal charges are dropped or the cases are plea-bargained. One study even reported that in a majority of cases (59%), judges failed to hold a formal hearing and simply relied on the competency reports provided by the mental health professionals to make an informal decision (Roesch & Golding, 1980). It could be argued that if the competency reports are being used as the sole basis for legal determination, that a forensic psychologist is by extension addressing a legal question and not a psychological one anymore. However, it is not clear whether the high rate of agreement is a result of the legal system abdicating its responsibility or is a reflection of the relatively low threshold for competency and the high quality of the reports.

Restoration of Competency

Treatment considerations are relevant to competency in the form of the restoration of competency for those individuals judged incompetent. As we previously stated, *Jackson v. Indiana* (1972) concluded that incompetent defendants "cannot be held more than a reasonable period of time to determine whether there is substantial probability that [they] will attain capacity in the foreseeable future" (p. 738). Prior to *Jackson*, incompetent defendants were largely held indefinitely. However, *Jackson* encourages restoration or treatment in order to avoid releasing a defendant who had potentially committed a crime. Though treatment response is not an inherent part of competency decisions,

jurisdictions now often include provisions for a determination of competence restoration after a defendant has been found incompetent (Nicholson & McNulty, 1992). **Competency restoration** refers to the process by which an incompetent defendant's competency is restored so that the legal process can continue. This process was especially relevant in the mass shooting in Tucson, Arizona, of Congresswoman Gabby Giffords and the deaths of six other bystanders in 2011. The suspect in the shooting, Jared Loughner, was initially found incompetent to stand trial (see Box 8.2). The restoration of competency can be accomplished through the use of psychotropic medication, psychotherapy, and psychoeducational interventions in which the incompetent defendant is educated about the legal system. Competency restoration tends to be successful, as less than one-quarter of incompetent defendants are identified as unlikely to be restored to competence upon an initial evaluation (Warren et al., 2006) and less than 10% of incompetent defendants are ultimately unable to be restored to competency (Nicholson, Barnard, Robbins, & Hankins, 1994; Nicholson & McNulty, 1992).

In general, incompetent defendants face short hospitalizations. Nicholson and McNulty (1992) found that the average length of stay for 150 randomly selected incompetent defendants was 68.8 days and that only 5.5% of defendants were held for 6 months. However, most studies suggest that incompetent defendants are more likely to be hospitalized for 4 to 6 months (Bennett & Kish, 1990; Golding, Eaves, & Kowaz, 1989; Rodenhauser & Khamis, 1988). Morris and Parker (2008) found that among approximately 1,500 admissions over 17 years 72.3% were likely to be restored within 6 months and 83.9% within 1 year. Although *Jackson* did not define a reasonable amount

Box 8.2. Jared Loughner: A Tragedy with Competency Implications

On January 8, 2011, Jared Loughner shot and killed six people and wounded 14 others in a supermarket parking lot in Tucson, Arizona. The shooting made national news in part because one of the wounded survivors was Congresswoman Gabrielle Giffords, who was shot in the head. This horrible tragedy has interesting implications for individuals involved in competency evaluations. Loughner was found incompetent to stand trial on May 25 of the same year and was remanded to a federal prison to evaluate the possibility of future competency and potential restoration. Through a series of legal rulings, Loughner was both forcibly medicated and granted the right to refuse medication if the medication was for the sole purpose of restoring his competency. This ruling was based on the fact that he had not been convicted of the crime yet. However, authorities did forcibly medicate him under *Washington v. Harper* (1990) in order to control the danger he posed in prison. He was later found competent to stand trial on August 7, 2012. During the competency hearing, his treating psychologist, Dr. Christina Pietz, testified that he had suffered depressive symptoms for the last 5 years and was diagnosed with schizophrenia in 2011. She stated that after being medicated for a year, he appeared to be very remorseful and was competent to stand trial. Loughner entered a plea agreement and on November 8, 2012, he was sentenced to seven consecutive life terms without parole.

of time, these results appear to be in keeping with the Court's mandate. There were also several variables related to length of stay in the hospital. Older, Caucasian, unemployed defendants with previous psychiatric admissions, who were living alone or in an institution, and were diagnosed with psychoses or an organic disorder experienced longer hospitalizations (Nicholson & McNulty, 1992).

The low base rate of defendants not restored to competency presents a problem for identifying the characteristics that are related to poor treatment response in incompetent defendants, but clinicians need to do so in order to identify those defendants who can be restored in a reasonable amount of time. Golding (1992b) suggested that poor functioning prior to onset of a mental illness, negative symptoms (i.e., symptoms that are characterized by an omission of normal characteristics such as inappropriate or flatted affect), a quick onset of symptoms, past psychiatric history, and a history of treatment response are the best predictors of treatment response in incompetent defendants. Carbonell, Heilbrun, and Friedman (1992) attempted to identify a list of predictors in a sample of defendants originally judged incompetent and included 38% of the sample that were not restored to competency within 3 months. Although they were able to identify those individuals who could not be restored with an accuracy of 77.2% in the original sample, they were only able to reach 59.5% accuracy using those same variables on a follow-up sample with the same high base rate of incompetent defendants who were not restorable (38%).

Nonetheless, most studies do not have sufficient numbers of individuals who could not be restored to competency and instead examine variables related to predictions made by the evaluators as to restoration capability. Hubbard and Zapf (2003) examined the variables related to competency restoration in a small sample of incompetent defendants of whom some were deemed restorable (37.1%), some were deemed unable to regain competency (21.3%), and some did not have a prediction clearly identified on the original report (41.6%). They found that those individuals who were restored to competency were more likely to have a previous criminal history, a current violence charge, a minor nonpsychotic diagnosis, previous mental health contact, previous hospitalization, and prior use of psychotropic medication. These results were similar to a larger sample from the same researchers (Hubbard, Zapf, & Ronan, 2003). Another study found that those individuals deemed uncertain or unlikely to be restorable tended to be older and men. Unlikely restoration candidates also were less likely to have prior convictions and more likely to be diagnosed with psychotic and mood disorders (Warren et al., 2006). Mossman (2008) found that a defendant was unlikely to be restored if the reason for the incompetence was a long-standing psychotic disorder with an accompanying history of hospitalization or a permanent cognitive disorder (e.g., mental retardation) that led to a limited understanding of any legal realities. Colwell and Gianesini (2011) found unrestorable defendants more likely to have previous hospitalizations, lower-level charges, more incarcerations, a psychotic or a cognitive disorder, more medications, and lower function in general. There may be some consensus in the limited research that defendants unlikely to be restored suffer from a psychotic diagnosis, are older, and have a diagnosis of mental retardation (Zapf & Roesch, 2011).

Competency Restoration Programs

There has been surprisingly little research on competency restoration and treatment of defendants found incompetent at a time when some have questioned the effectiveness of the treatment of incompetent defendants (Mumley, Tillbrook, & Grisso, 2003). The lack of research may be because competency restoration is simply the implementation of traditional treatment approaches to improve overall mental health, but this notion seems counterintuitive in light of the increasing use of specialized forensic units to treat these types of offenders (Clark, Holden, Thompson, Watson, & Wightman, 1993). Unlike the movement of the evaluation process to outpatient sources, the treatment of incompetent defendants has largely remained within inpatient facilities (Miller, 2003). Research comparing the two approaches is even less available than empirical support of competency restoration in general.

An initial step in most competency restoration interventions is the administration of medication, primarily to reduce psychotic symptoms (Cooper & Grisso, 1997). This approach seems very relevant given the relationship between psychosis and an initial finding of incompetence and the restorability of incompetent defendants. The typical incompetent defendant exhibits significant psychiatric impairment and legal parties appear to take this impairment into account when referring individuals for competency evaluations. However, the administration of medication is not a routine matter when dealing with incompetent defendants. For some defendants, it may seem a very reasonable choice to refuse medication in order to avoid prosecution. However, the Court has continually upheld the state's right to forcibly medicate individuals (*Riggins v. Nevada*, 1992; *Sell v. United States*, 2003; *Washington v. Harper*, 1990). *Sell* specifically stated that medication could be forcibly administered for the restoration of competency in cases where the medication is substantially likely to render the defendant competent and substantially unlikely to interfere with the ability to assist counsel. Not only do *Sell* and the other cases solidify the government's right to involuntarily medicate a defendant, but research suggests that incompetent defendants do not routinely refuse medication for legal strategy but instead do so because of delusions about their medication or denial of their mental illness (Ladds & Convit, 1994).

In addition to medication, competency restoration typically involves an educational or psychoeducational component. When talking about competency restoration in my class, I typically go into an elaborate discussion about the complexity of the process and state that it is very difficult to try to communicate the precise nature of such an involved process to students. Then I flip on the DVD of a courtroom scene from the movie *A Few Good Men* or an episode of the television show *Law & Order* (see Figure 8.1). I then whip out a hastily drawn picture of a courtroom with a judge's bench, a jury box, the two tables for the attorneys and the other respective participants and quiz the class about where everyone sits and their purpose. Obviously, my previous comments about the complexity of the process seem ridiculous because this aspect of competency restoration tends to be straight forward. Remember, the threshold for competency is very low. A defendant needs to be able to communicate with her attorney and understand the nature of the legal proceedings. If a defendant is medicated and

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Figure 8.1. A picture of the fictional character, Dr. George Huang. *Law & Order* and B. D. Wong (Huang) have been publicly acknowledged for their accurate portrayal of forensic psychology/psychiatry.

her delusional belief that she is Britney Spears has been addressed, she may only need to be educated about the nature and consequences of the process. Can she identify the judge and jury? Are they out to get her or are they supposed to be objective and help decide whether she is ultimately guilty? These are the types of issues that are addressed in the psychoeducational component of competency restoration.

Generally, these types of approaches have been effective. Siegel and Elwork (1990) described a psychoeducational group that met for 1 hour each week for 7 weeks. The group consisted of lectures, videotaped presentations, use of courtroom models, role-playing, and problem solving focused specifically on the competency to stand trial. A control group received identical treatment in terms of the length and time involved but it focused on more general mental health problems. Results showed that the experimental group in the specially designed treatment group showed greater improvement and were more likely to be recommended as competent. However, Anderson and Hewitt (2002) were able to restore only 18% of a sample of mentally retarded defendants. Bertman et al. (2003) compared standard hospital treatment, legal rights education, and competency-related deficit-focused treatment. They found that standard treatment did not result in lower scores on posttreatment measures of competency, but the other two individualized treatment programs did. However, it was not clear whether this was

because of the greater number of individual sessions or the characteristics of the treatments themselves.

However, incompetent defendants often have received the same general treatment as civilly committed psychiatric patients (Grisso, 1992) and the general conditions in mental health hospitals have been criticized (Winick, 1983). Moreover, it is not clear that the additional educational components have any effect beyond the effectiveness of psychotropic medications (Zapf & Roesch, 2011). Courts have even stated that incompetent defendants are often committed to maximum security wards at mental hospitals and this may be contrary to effective treatment (*Covington v. Harris*, 1969). It also can be argued that some psychoeducational treatments encourage an artificial competence in that defendants, especially defendants suffering from mental retardation, may be able to pass a multiple-choice exam on the different components of a courtroom because of their recent education but not truly improve in their inherent understanding and assistance during the process. Furthermore, defendants receiving treatment involuntarily also benefit (Ladds & Convit, 1994); in fact, one study indicated that defendants who initially refused medication were more likely to be restored to competency (Rodenhauser & Khamis, 1988). Finally, there is very little information on incompetent defendants who are restored to competency and recidivism rates. Beckham, Annis, and Bein (1986) conducted a small study and found that 14% of patients who were restored to competency recidivated and that a decrease in medication at discharge and facing a more severe charge were related to recidivism.

Other Criminal Competencies

The discussion so far has focused on competency to stand trial because of the expansive literature on this aspect (Zapf et al., 2002) and the legal decisions equating different competency issues (*Godinez v. Moran*, 1993). Despite encouragement by the legal system to treat competency identically across different points in the adjudication process, scholars continue to argue for context-specific competency evaluations in which the particular abilities necessary to plead, confess, be sentenced, or be executed are examined. However, there are still other scholars who argue there is no or little empirical support for the notion that different contexts require different abilities, despite the calls in the literature to treat them as such (Coles, 2004). Nonetheless, the Supreme Court may be reconsidering equating all forms of competency. In *Indiana v. Edwards* (2008), the Court held that defendants who are defending themselves in court, pro se defendants, may require a higher standard of competence. Similar future legal decisions may encourage additional research on other areas of competency, especially as they become more frequent.

Competency to Be Executed

Though the U.S. Supreme Court has ruled that two groups for which competency is a significant issue (i.e., those suffering from mental retardation and juveniles) are not eligible for the death penalty, competency for execution is raised with increasing frequency.

Prohibitions against executing an incompetent defendant have historical roots separate from general competency and can be traced back to the thirteenth-century notion that someone facing execution should be able to put his or her spiritual affairs in order to prepare to face God (Heilbrun, 1987). In *Ford v. Wainwright* (1986), the U.S. Supreme Court case formally recognizing the competency rights of defendants facing execution, Alvin Ford began to show increasingly delusional behavior while on death row. His odd behavior began with the occasional peculiar idea but grew more serious and included a complex conspiracy involving the Ku Klux Klan and the prison guards, torture and abuse of his female relatives, a hostage crisis involving his family members, and his appointment as Pope. Though the Court recognized that Ford was not sufficiently competent to be executed, it did not identify a specific standard for competency to be executed, though *Panetti v. Quarterman* (2007) did offer some more specific guidelines for clinicians. Nonetheless, research has begun to examine forensic measures to be used in these evaluations (Ackerson, Brodsky, & Zapf, 2005; Zapf, Boccaccini, & Brodsky, 2003). Competency for Execution (CFE) evaluations may be especially problematic for forensic psychologists because of the inherent political and ethical issues involved in capital punishment (Neal, 2010). As a result, forensic psychologists must be aware of their personal biases when rendering these conclusions. See Box 8.3.

Competency to Waive *Miranda* Rights

Another area of competence that has received increasing attention is the ability to confess and waive the right to counsel. In the United States, the ability to confess and waive counsel is tied to the Supreme Court decision in *Miranda v. Arizona* (1966) in which specific criteria were identified for suspects to be interrogated and make confessions. As a result, competency to confess and competency to waive one's *Miranda* rights are often interchangeable in the United States (Brodsky & Bennett, 2005), even though there are other factors that should be considered in assessing whether a confession is valid (Greenfield & Witt, 2005). *Miranda* established that suspects must have the ability to knowingly, voluntarily, and intelligently waive their rights. Grisso (2003b) stated that a suspect must be able to understand the words and phrases included in the *Miranda* warning and be clear about the purpose of the *Miranda* warning, such as an awareness of the adversarial nature of the legal system and the right against self-incrimination. There have been specialized forensic measures developed to assess competency to confess but there is disagreement about the reliability and validity of those instruments (Grisso, 2004; Rogers, Jordan, & Harrison, 2004).

Competency to Refuse the Insanity Defense

Another competency issue facing the courts is competence to refuse the insanity defense. Though the courts have not been completely consistent on the issue (Litwack, 2003), *Frendak v. United States* (1979) did find that a defendant must understand the plea's availability and the consequences of entering an insanity plea. The ability to refuse an insanity defense was a central feature in the criminal trial of Ted Kaczynski,

Box 8.3. Focus on Research: Bias in Capital Evaluations?

Pirelli & Zapf (2008) conducted a national study of forensic psychologists about their attitudes toward capital evaluations. They surveyed 231 licensed forensic psychologists via mail. Psychologists generally responded that they were not opposed to participating in most of the different types of evaluations involving capital punishment. However, psychologists voiced the greatest opposition to competency to be executed evaluations, with only a minority (46%) seemingly willing to participate in these evaluations, whereas 71% to 85% expressed willingness to participate in other death penalty evaluations (e.g., competence to stand trial, violence risk assessment, sentencing). These results highlight the clear difference between these evaluations and not only other forensic evaluations but even other evaluations within the context of a death penalty case. However, the results also suggest that forensic psychologists are aware of some of their biases and reduce the impact of those biases by avoiding these cases. Pirelli and Zapf also identified predictive models for assessing participation in these evaluations. Psychologists who reported that their personal views on the death penalty would impact their decision to participate and reported less experience in the capital arena reported greater opposition to participating in these evaluations in general. Overall, psychologists endorsed stances suggesting greater ethical soundness by agreeing that capital evaluations dictate more attention than non-capital evaluations and that psychologists wishing to participate in this area should specialize in it.

This study suffered from some of the same problems often found in survey research such as the possibility of prosocial responding, the use of estimates regarding forensic practice history, and a 50% response rate. Response rates are especially important in this type of research in order to capture enough people to minimize the likelihood of responders differing from nonresponders and thereby influencing the final results. Another important note is that the researchers never asked if participants would or would not participate in these evaluations (yes or no) but instead assumed it by asking them to respond on a 5-point Likert-type scale from strongly opposed to not at all opposed. This seemingly small decision in the responses availability can be key in research and is a potential limitation in communicating the findings of this particular study.

the notorious Unabomber. Kaczynski mailed bombs to numerous people who worked in university and industry settings over three decades because of a belief in the inherent evils of technological progress. His actions resulted in the death of 3 individuals and wounding of many others. Kaczynski was adamant at trial that he would not pursue a plea of insanity, against his attorneys' advice, because he did not want to be seen as mentally ill. He believed being mentally ill would diminish the credibility of his claims about technological progress. However, he agreed to a plea to avoid the death penalty and the issue was not decided by the court.

Civil Competencies

Completely separate from the criminal competencies are the civil aspects to competency. Competency is raised in a variety of issues including employment, professional

competency, competency of a witness, competency to consent to sexual activity, competency to participate in mediation, competency to make a will, competency to enter into a contract, and competency to make medical decisions (see Abrams, 2010, for a detailed discussion). Civil competencies generally focus on an individual's ability to understand any of the information that is relevant to making an everyday decision. An individual must be able to understand the information relevant to the decision, apply that information to his or her situation, use rational thought to evaluate the benefits and consequences of any decision, and communicate the decision (Grisso, 2003b). It could be argued that the specific threshold or standard for civil competency is more dependent on the context of the decision than the adjudicative competencies previously examined because of the greater variety of contexts in which an issue of civil competence may arise.

Competency to Be Treated

Informed consent is typically required for any individual seeking medical care and usually consists of the health care professional identifying the risks and benefits. However, health care providers can act without consent if the patient is unable to give consent because of incapacitation, there is a greater risk of harm if treatment is delayed, a reasonable person would consent, or the person would normally consent to treatment (Slovenko, 2006). In some cases, a determination by the court must be made whether any of these conditions apply. For example, mentally ill individuals may be unable to make a treatment decision. Though research suggests that the majority of the mentally ill are competent to make treatment decisions, there are a number of mentally ill individuals who are not competent to make these decisions (Grisso & Appelbaum, 1995). Because these issues do not arise in the midst of legal proceedings, treatment decisions are often delayed or consent is sought from family or institutional boards. When these issues come before a court, there are instruments designed to assess competency relative to treatment with varying degrees of psychometric soundness. The MacArthur Competence Assessment Tool for Treatment (MacCAT-T) is one of the more recently developed measures (Grisso & Appelbaum, 1998) and is related to three other measures that were previously designed to assess competence to make treatment decisions. The MacCAT-T consists of an interview focused on understanding the disorder, appreciation of the disorder, understanding treatment, understanding the risks and benefits of treatment, appreciation of treatment, awareness of alternative treatments, patient choice, and the consequences of the choice (Grisso & Appelbaum, 1998). Competency to be treated has undergone significant improvement in the past 20 years but there appears to be room for improvement in the development of measures and the application of these measures to the clinical evaluations.

Competency to Execute a Will

Every person who makes a will must be able to make competent decisions about the division of his or her property and personal belongings. The person making a will, the **testator**, must understand the nature of the property, identify the individuals eligible

to receive the property upon death, and identify the specific property to be assigned to them (Slovenko, 2006). Usually, the only way for a potential heir to contest or challenge a will is to challenge the capacity or competency of the testator to make the will. It should be clear that a testator does not have to be competent to formally write out the will, as an attorney will do that part. He or she must have the capacity to make competent decisions about the division of the property. The threshold for competency to execute a will is relatively low compared to the competency to perform other civil responsibilities such as entering into a contract (Slovenko, 2006). In *Banks v. Goodfellow* (1870), the legal standards for competency to execute a will were established such that a person must know he or she is making a will, know the nature of the property, and know the manner in which the will distributes the property.

Performing competency evaluations for the execution of a will can be especially difficult. The person of interest is often dead and not available to be directly assessed. As a result, the evaluator must often rely on past records and information from third parties to assess the competency of the testator. Even though the threshold for competency to execute a will is low, the presence of a mental illness is not sufficient to find someone incompetent (Melton et al., 2007). These evaluations typically focus on the testators' functional abilities as they relate to the relevant legal criteria such as understanding the purpose of the will. The forensic psychologist also must determine the extent of the testator's property and the relationship between the testator and his or her family and friends that might suggest their preferences. These types of evaluations appear to be less structured with more varying standards of practice than the previous areas, which might have had structured measures or interviews developed for the specific purpose.

Competency Related to Guardianship

Guardianship is the identification of an individual by the state to make legal decisions for another person who is no longer able and may be the oldest issue in mental health law (Melton et al., 2007). All individuals are naturally assumed to be competent, so a guardian is appointed after it has been determined in court that an individual is no longer able to make competent decisions in her own best interest. A guardian may be necessary for a variety of reasons. A person may be unable to make decisions in regard to her own health care, the use of her own financial resources, or caring for any of a person's basic needs. Moye (2003) believes that guardianship evaluations may be the most difficult in all of forensic psychology because of the broad issues that must be addressed in them.

Determining the need for guardianship may be fairly easy if the person is civilly committed or otherwise incapacitated. Therefore, competency evaluations are more likely necessary when this situation has not arisen. In these instances, a person must petition the court to find someone incompetent and in need of a guardian. Though these decisions may be the most difficult for forensic psychologists, they tend to be the most informal from a legal standpoint (Melton et al., 2007). For example, many states do not require formal evaluations (Thor, 1993). As with other competency issues,

clinicians should emphasize the functional abilities of the person as they relate to the specific task or even a broad range of tasks, if they are relevant to the question before the court. At least one measure has been developed for the assessment of guardianship, the Community Competence Scale (CCS). The CCS was developed to assess daily life skills across 16 different subscales in order to improve the reliability and validity of these types of evaluations (Searight, Oliver, & Grisso, 1983). There are also a variety of measures that focus on related abilities such as daily living skills, neuropsychological and cognitive deficits, and mental health problems (Moye, 2003). It is also important to the evaluator in these instances to identify whether any deficits are the result of incompetence or a lack of education or experience.

Reflection and Review

1. When can competency be raised during the legal process?
2. Should the level of competency differ across the different areas of competency?
3. Should people be forcibly medicated in order to be made competent?
4. How do the civil competencies differ from criminal competencies?
5. What area of competency does most of the research focus upon?

Key Terms

competency restoration
fitness
functional abilities
in absentia
testator

Further Readings

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9 Insanity, Criminal Responsibility, and Diminished Capacity

Chapter Objectives

1. Be able to differentiate insanity from competency and civil commitment
2. Describe the major legal standards for insanity
3. Discuss the major instruments and issues involved in performing insanity evaluations
4. Identify the additional issues related to criminal responsibility and diminished capacity

The insanity defense has been a controversial aspect of criminal law throughout history. Even today, the public is drawn to high-profile cases in which an individual admits to a particular act but argues he was insane at the time. Andrea Yates was a mother of five children under the age of 8 with an extensive history of mental illness and psychiatric hospitalization. In March 2000, she drowned her five children in a bathtub, one after the other, and then placed them on her bed. She claimed she had to do it because she was not a good mother and she needed to be punished. Her defense was insanity but she was found guilty of first-degree murder in her original trial and later sentenced to life in prison. The Andrea Yates case represents the controversial nature of insanity. Some people were shocked by the verdict and wondered how anyone who killed her five children under such a delusional belief could be anything but insane. Others argued that anyone who kills five small children must be punished for the crime and it would be unjust to find her insane. See Box 9.1 for more information on the second trial of Andrea Yates.

Despite the controversy surrounding the insanity defense itself, there has long been a widely held belief that some people should not be held responsible for their criminal behavior. Platt and Diamond (1965) trace this notion back to the Talmud, a Jewish holy

Box 9.1. Second Trial of Andrea Yates

The Andrea Yates case was certainly of interest to the public because of the tragic death of her children. However, the case was of great interest to legal scholars and forensic psychologists for other reasons. In her first trial Yates was found guilty and sentenced to life in prison. On appeal, a Texas Court of Appeals overturned her original conviction because of an error by one of the expert witnesses in the case, Dr. Park Dietz. Dr. Dietz is a nationally known psychiatrist and testified for the prosecution that Yates was sane at the time of the crimes. Dietz has worked on a number of high-profile cases including John Hinckley, Ted Kaczynski (the Unabomber), and Jeffrey Dahmer.

The reversal of the original guilty verdict was because of an inaccurate statement Dietz made during his testimony. A complete reversal of a criminal conviction on the basis of a mental health professional's expert testimony is noteworthy and Dietz received a great deal of media attention for the mistake. He recalled during his original testimony that Yates had gained the idea for killing her children from the television show, *Law and Order*. Dietz was a consultant for the show and he argued that an episode had aired shortly before the murders in which a woman drowned her children and was found not guilty by reason of insanity. The prosecutors even emphasized this fact in their closing arguments. However, there was one problem with the testimony. It was incorrect because the episode Dietz described never aired, as defense attorneys soon figured out, and as he admitted in a letter to the court before the end of the trial. The defense attempted to get the judge to declare a mistrial, but the judge refused. The appeals court believed the trial judge erred in not awarding a mistrial and a new trial was ordered. In her second trial, Andrea Yates was found not guilty by reason of insanity because she suffered from postpartum depression and did not know what she was doing was wrong, under Texas law. She is now likely to spend the rest of her life in a mental institution.

book, where they quote it as saying, "A deaf mute, an idiot and a minor are awkward to deal with, as he who injures them is liable [to pay], whereas if they injure others they are exempt" (p. 1228). The notion of criminal responsibility includes insanity but is more extensive and refers to any situation in which someone lacks the mental state required by the law to be guilty of a given crime. This chapter will focus largely on criminal responsibility as it relates to insanity but we will also briefly examine other aspects of criminal responsibility.

At this point in the mental health law section of the text, it should become apparent that there is significant interplay between civil commitment, competency, and now insanity. Many students new to this area of forensic psychology become confused about the differences between insanity and competency specifically because they are related but distinct aspects of the legal system (Gates, 2003). To confuse the matter further, sometimes the courts even use the more colloquial term *insanity* to refer to instances in which the issue is one of competency (Ackerson, Brodsky, & Zapf, 2005). First, to distinguish the two concepts, remember that insanity focuses on an individual's mental state at the time of the crime. Insanity evaluations are a retrospective examination of an individual's mental state, because the forensic psychologist has to go back in time.

Competency evaluations, on the other hand, focus on an individual's mental state at the current moment. The focus is on the present, whenever that moment may be occurring in the legal process. However, the one problem with this distinction is that competency evaluations do not always concern a person's current mental state. For example, individuals will be evaluated for their competence related to standing trial, refusal to enter an insanity plea, and definitely prior to being executed as they are facing these situations. In these situations they will be evaluated for their present mental state. However, it is unlikely that a law enforcement officer attempting to gain a confession from a suspect he believes is guilty is going to discontinue an interrogation and ask a forensic psychologist to conduct a competency evaluation to make sure the suspect understands the ramifications of any confession. Thus, there are instances in which a forensic psychologist must perform a retrospective examination of competency.

Second, insanity is a legal defense to a criminal charge. A finding of insanity is a legal verdict that results in the defendant being found not guilty. A finding of incompetence leads to a postponement in the legal proceeding. For example, a defendant who is found incompetent to stand trial is not simply released but is more likely to be referred to a mental health facility in order to restore his or her competency and then face trial once competency is restored.

Third, the standards for competency and insanity are vastly different. Insanity requires the presence of a mental illness. Although the threshold for competency involves a defendant's mental state, most competency standards do not require the presence of a mental illness, even though most of those found incompetent suffer from a mental illness.

Fourth, a competency evaluation does not require that a defendant admit to committing the crime. Defendants must only know the meaning of the charges and the consequences of their actions at any point in the process to be competent (Gutheil, 1999). In fact, a report focused solely on competence typically does not include any statements made by the defendant concerning the crime (Sales, Miller, & Hall, 2005).

Civil commitment also has a complex relationship with both insanity and competency. Competence to give informed consent or competence to refuse medical treatment (see Chapter 8) have direct application to civil commitment because these individuals are frequently civilly committed in order to treat their mental health issues. Individuals who have been found Not Guilty by Reason of Insanity (NGRI) are routinely civilly committed immediately after their acquittal, as are many individuals found competent but unrestorable. However, there are also clear differences between competency, insanity, and civil commitment. Despite the significant legal and practice differences, it is easy to get them confused. First, although each focuses on someone's mental state, insanity and civil commitment always require the presence of a mental disorder or defect, while competency does not in many jurisdictions. Second, competency tends to focus on someone's present mental state, insanity focuses on past mental state, and civil commitment focuses both on present and future mental state because it may require an assessment of future dangerousness. Third, insanity is raised in criminal proceedings, civil commitment is a civil issue, and competency can be either a criminal or civil issue. These distinctions should help keep the three issues separate throughout the rest of the chapter (see Table 9.1 for a summary).

Table 9.1. Comparison of Insanity, Competency, and Civil Commitment

Civil commitment	Insanity	Competency
Requires presence of mental illness	Requires presence of mental illness	Does not require presence of mental illness
Focuses on future and present	Focuses on past	Focuses on present
Civil issue	Criminal issue	Civil and criminal issue

Finally, insanity is not the only issue that falls under criminal responsibility. The bulk of this chapter will focus on insanity but we will briefly address some other issues that arise in the practice of forensic psychology in regard to criminal responsibility.

Rationale for Insanity Defense

The insanity defense is a legal defense that results in the removal of legal responsibility. A defendant found insane is normally referred to as Not Guilty by Reason of Insanity (NGRI) or in some jurisdictions as Not Responsible by Reason of Insanity (NRRI). In either case, the person is referred to as acquitted, just as someone who is found not guilty of a crime. As described in Chapter 1, U.S. criminal law requires mens rea, a guilty mind, for someone to be found guilty or held responsible for most crimes. Mens rea refers to someone intentionally committing a criminal act with a guilty or wrongful purpose. This standard also is expressed in the Latin phrase *actus non facit reum nisi mens sit rea* ("the act will not make a person guilty unless the mind is also guilty"). An act and the mental state must be present for someone to be guilty of many crimes. In instances in which someone lacks mens rea or it is reduced, criminal responsibility is eliminated or diminished. In the case of insanity, it is the presence of a mental illness that can remove criminal responsibility.

Insanity is viewed as a legal compromise to a moral dilemma because society believes it is inappropriate for people who do not know what they are doing or who cannot control their behavior to be punished. As a result, insanity focuses on an individual's mental state at the time of the criminal act and is often referred to as mental state at the time of the offense, or MSO. It is important to remember that insanity refers to someone's mental state at the time of the criminal act, while competency focuses on someone's mental state during the adjudication process.

One misconception, among many misconceptions that we will discuss in this chapter, is that insanity is a mental illness or is equated with mental illness. Even though the presence of a mental illness or mental defect is central to the different laws that define insanity, insanity is not identical to mental illness. Insanity is a legal term, not a psychological or psychiatric term. You will not find the term *insanity* listed in the DSM with the diagnostic criteria alongside it as you would other mental illnesses. Someone may suffer from a mental illness and not be insane. Insanity normally requires a level

of impairment that is more specific than simply suffering from a mental illness. Moreover, not all mental illnesses are sufficient to establish an insanity defense, as we will discuss later.

Insanity Standards

Part of the controversy surrounding insanity is exemplified in the numerous descriptions or standards of insanity that have existed over time. There are indications that crude standards for insanity date back to at least the thirteenth century in England (Goldstein, Morse, & Shapiro, 2003). However, it was not until the eighteenth century that these crude notions became more formalized. The intended effects of these changes are another example of the ability of the law to have positive or negative consequences. The definition or standard for insanity has been routinely changed over time because of concern about it being too lenient or sometimes too harsh. There have been continued refinements in hopes that only those people who are truly insane will be acquitted (see Table 9.2).

Table 9.2. Insanity Changes over the Years

Alteration in insanity	Intent of the alteration
Wild Beast test (1724)	Insanity indicated by total deprivation of understanding and memory and a lack of knowledge of what he is doing anymore than an infant, a brute, or a wild beast.
M'Naghten (1843)	Insanity applies if the defendant suffers from a defect of reason, from disease of the mind, as not to know the nature and quality of the act, or did not know he was doing wrong.
Durham or product rule (1954)	Insanity applies if the crime is a product of mental disease in the defendant.
ALI or *Brawner* rule (1972)	A person is insane if he lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of the law because of mental disease or defect.
Insanity Defense Reform Act (1984)	Made four significant changes in the federal insanity law: (1) removed the volitional prong; (2) barred ultimate issue testimony; (3) switched the burden of proof to the defense; and (4) changed standard of proof to clear and convincing evidence.
Guilty But Mentally Ill (GBMI) (1975)	An accused may be found GBMI if he is guilty of the crime, he was mentally ill at the time of the offense, and he was not legally insane.

Wild Beast Standard

One of the first formalized standards of insanity was the **wild beast test**. In early in English common law, a defendant who was believed to be insane was found not guilty, but there was not a specific standard for insanity. In 1724, an English judge, Judge Tracy, formally recognized the legal standard that became known as the wild beast standard (*Rex v. Arnold*, 1724) by stating that for someone to be insane he must be totally deprived of his understanding and memory, and not know what he is doing anymore than an infant, a brute, or a wild beast. Such a person should never be punished (Platt & Diamond, 1965). The belief was that someone who was not responsible for his behavior had no more control over his behavior than a wild beast. However, the notion of the wild beast had been around for centuries and was not completely novel to English common law at the time of Tracy's opinion (Platt & Diamond, 1965).

M'Naghten

The wild beast test dominated English law until 1843 and the *M'Naghten* case. The *M'Naghten* case is most frequently identified as the first modern insanity standard. Although "M'Naghten" has been spelled a number of different ways (e.g., McNaughton), we will use the spelling in the original case facts (Goldstein et al., 2003). Daniel M'Naghten appeared to develop a complex delusional belief system that focused on the ruling political party at the time, the Tory Party. M'Naghten believed officials in the Tory Party were out to get him and were going to murder him. He decided to travel to London in order to kill the Prime Minister and end his own persecution and murder. However, he mistakenly killed the Prime Minister's secretary, Edward Drummond, by shooting him with a pistol (Moran, 1981). M'Naghten's defense team decided to raise an insanity defense. The prosecution agreed that M'Naghten was mentally ill but instead encouraged use of the wild beast test, claiming that his mental illness was not severe enough to justify complete removal of responsibility. Nine expert witnesses testified that M'Naghten was insane because his delusional beliefs made him unable to tell the difference between right and wrong. The judge instructed the jury to find M'Naghten insane and he was committed to a mental hospital for the rest of his life (Verger, 1992).

Public outcry and a reconsideration of the insanity defense is a common result throughout history when a high-profile case ends in an insanity verdict (Poulson, Braithwaite, Brondino, & Wuensch, 1997). *M'Naghten* was no different from later instances, except that the protest was even greater (Freemon, 2001). The public outcry and personal concerns of Queen Victoria, who had received death threats in the past, resulted in a debate in the House of Lords over the use of the insanity defense. Ultimately, the *M'Naghten* standard was the rule of law (Moran, 1981). The standard stated

> . . . it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong. (*M'Naghten* Case, 1843, p. 722)

As with all the modern approaches to insanity, the ***M'Naghten* standard** first states that the defendant must suffer from a mental illness or "disease of the mind." However, a disease of the mind was not clearly defined at the time and the courts continue to largely ignore a precise definition of mental illness for insanity (Slovenko, 1999; Winick, 1995a). The second prong of *M'Naghten* focuses on the inability to know the nature or quality of the act. This prong is somewhat vague and has two parts, a focus on the *nature* and the *quality* of the act. Courts have interpreted the nature of the acts as pertaining to the physical aspects of the crime. For example, did the defendant know when he placed the poison in his roommate's Red Bull that he would drink it and it would enter his bloodstream? Very few defendants fail to meet this requirement of *M'Naghten* (Verger, 1992). The quality of the act suggests that the defendant must know the potential harm that could occur. A very common metaphor used to describe this aspect of *M'Naghten* suggests that a man who chokes a victim believing he was squeezing a lemon would be unable to know the quality of his act. He could not have known that by squeezing a lemon he would be killing a human being.

The third prong of *M'Naghten* focuses on knowing right from wrong. Although this approach was not novel in English law (Zapf, Golding, & Roesch, 2006), it is not completely clear whether the intent was to focus on legal or moral differences. This distinction can be very important, such as in the original trial of Andrea Yates. It was relatively clear that Andrea Yates knew she would be arrested for murdering her children because she called police to report the crime and thereby indicated she knew it was legally wrong. However, it was argued that she believed her actions were morally right because she was saving her children. The original jury decided that Texas law focused on the legality of the act, not the morality of the act, and therefore found her guilty. If Andrea Yates had believed she was only giving her children baths, the question of legal or moral wrong would not have been an issue because she would not have known the nature and the *quality* of the act.

M'Naghten has been criticized as being too narrowly focused or too conservative (Weiner, 1985) and is normally seen as a more conservative approach to insanity that is likely to result in fewer insanity acquittals than the remaining two modern insanity standards. *M'Naghten* focuses almost exclusively on the cognitive aspects of insanity by emphasizing a defendant's intellectual ability to know and ignores the volitional aspects that could be impaired by a mental illness. Volitional refers to a person's ability to choose a given course of action. An insanity standard that considers volition would generally recognize problems with impulse control. Donohue, Arya, Fitch, and Hammen (2008) actually examined the frequency with which the cognitive and volitional prongs of *M'Naghten* were utilized in a sample of 416 defendants from Maryland. They found that only 11% of the defendants were identified as insane because of volitional impairment alone (usually a drug-related offense) and suggested that results of their study should reduce concerns about the abuse of a volitional prong.

Despite this narrow focus, *M'Naghten* was widely adopted across the United States, though it was challenged early because of its narrow focus (Zapf et al., 2006). Several states began to reconsider the conservative nature of *M'Naghten* and included an **irresistible impulse test** with it after the initial adoption of the standard. The irresistible

impulse test normally suggests that even if a defendant knows the nature and quality of an act and is aware that it is wrong, he may be unable to stop his behavior. For example, assume that Mikey has been suffering from command hallucinations telling him to purchase ceramic lawn gnomes to protect his house from intruders. Mikey may resist the voices because he does not have any money in his checking account and cannot afford the lawn gnomes. He knows it would be wrong to write the check without sufficient funds but suppose the voices overpower him and he is unable to resist the urge to purchase the lawn gnomes from the Home Shopping Network. In this instance, the defendant could qualify as insane under the irresistible impulse test. A law review article at the time noted that *M'Naghten* had been fully adopted, altered to include some mention of an irresistible impulse test, or been replaced by a new standard, the product rule, by the early 1900s (Crotty, 1924).

M'Naghten continues to be the most prominent standard for insanity in the United States in some form. Reviews of the relevant state laws suggest that some version of *M'Naghten* is the insanity standard in about 26 states (Packer, 2009). The Canadian insanity defense states that a defendant can be found insane if he or she is suffering from a mental disorder that resulted in his or her failure to understand the nature of the act or to know that it was wrong (as cited in Viljoen, Roesch, Ogloff, & Zapf, 2003). This standard appears very similar to the standard used in most jurisdictions in the United States (Viljoen et al., 2003). Nonetheless, there are two other significant insanity standards that have been, and continue to be, used in the United States.

We can start to see some of the potential scope of practice issues for forensic psychologists in this first of the modern insanity standards. Forensic psychologists should be able to evaluate the presence of a mental illness. It is one of the key aspects of their training. However, are they capable of doing so retrospectively, days or months after a crime has been committed and the defendant is now medicated or had time to recover from their previous psychological difficulties? We have talked about forensic psychologists determining someone's cognitive abilities like intelligence and memory. However, are forensic psychologists able to take those abilities and determine if someone knew the difference between right and wrong or knew what they were doing? Are they able to do so in a way that conforms to precise legal wording? These are important questions in discussing the remaining standards. They are also probably questions without a definitive answer, but they are important to keep in mind now and in our later discussion regarding the reliability and validity of insanity evaluations.

The Product Rule and *Durham*

An 1869 New Hampshire case first established use of the so-called **product rule** (*State v. Pike*, 1869). This standard is referred to as the product rule because the court declined the more complex approach specified in *M'Naghten* in favor of finding a person insane if the crime "was the offspring or product of mental disease in the defendant" (*State v. Pike*, 1869, p. 442). In 1954, the United States Court of Appeals in the District of Columbia adopted the product rule and it became known as the ***Durham* rule**. In *Durham v. United States* (1954), Monte Durham was charged with "housebreaking and

petit larceny" and pled insanity (Weiner, 1985, p. 9). The influential Judge Bazelon (the same judge who later presided in *Jenkins*) wrote the court's opinion, stating that experts should be given as much latitude as possible in these determinations and that a defendant was legally insane if the crime was a product of a mental disease or defect. This decision applied only to federal courts, but because of the influence of Judge Bazelon and the DC Court of Appeals, the *Durham* rule made a significant impact on the thinking of the time (Goldstein et al., 2003).

However, there were several problems with the *Durham* rule. First, it assumed that forensic psychologists and other mental health professional could agree on the constructs that constituted a mental disease or defect. The DC Court attempted to remove this problem in *McDonald v. United States* (1962) by ruling that the mental disease or defect had to substantially impair the defendant. Second, it was much harder to determine whether a criminal act was the product of a mental disease than had been assumed. Some experts believed it should be a narrow definition, which suggested that without the presence of the mental illness the defendant would not have committed the crime. Others suggested a much broader emphasis by considering the defendant's entire life as a possible motivator for the crime. Courts began to believe experts had too much input in insanity defense cases and that defendants were increasingly being found insane, based on the testimony of experts and the accompanying default decisions by the courts (Weiner, 1985). As a result, *Durham* is considered the most liberal or expansive of the three modern insanity standards. The courts tried to remedy the perceived problem of expert reliance, while still maintaining *Durham*, by ruling that mental health professionals could not testify about the connection between the mental disease and the criminal behavior (*Washington v. United States*, 1967), thereby eliminating ultimate issue testimony and putting the decision back in the trier of fact's hands.

American Law Institute (ALI) Rule and *Brawner*

As *Durham* continually met with opposition and was only incorporated within New Hampshire and Maine (now an ALI state) outside of the DC court's ruling, alternative standards for insanity were considered (Weiner, 1985). The American Law Institute (ALI) considered the issue of insanity in the 1950s and drafted an alternative standard that attempted to avoid the problems of *M'Naghten* and *Durham*, publishing the standard in its Model Penal Code. The ALI is a group of lawyers that draft proposed laws and suggest legal reforms but do not have any legal authority to make these changes binding law. The Model Penal Code (1962) states:

> A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of the law. (Section 4.01)

In addition, the Model Penal Code explicitly states that any mental disease or defect that is characterized by repeated criminal behavior is excluded from consideration.

The **ALI standard** differs from *M'Naghten* and *Durham* in several ways. ALI moves away from the exclusively cognitive emphasis of *M'Naghten* by using the word "appreciate" to suggest a more emotional or affective component to insanity. The defendant also does not need to exhibit a total lack of appreciation but only a substantial appreciation. Therefore, an individual does not have to exhibit profound impairment in all judgments to qualify. In addition, the phrase "conform his conduct to the requirements of the law" is similar to the irresistible impulse test and suggests a volitional consideration. The ALI standard was formally adopted by all federal courts in *United States v. Brawner* (1972) and many states also have adopted it. The ALI or ***Brawner* rule** is viewed as a compromise between *M'Naghten* and *Durham*. It incorporates cognitive, affective, and volitional aspects of mental illness while encouraging forensic psychologists and other mental health professionals to make a diagnosis and leave the ultimate decision up to the jury or judge. However, critics continue to argue that *Brawner* is too inclusive and allows too many defendants to be found insane.

Insanity Defense Reform Act (1984)

As has been seen with previous revisions in insanity standards, public criticism resulted in yet another change in the legal requirements for insanity. The high-profile crime in this case was the attempted assassination of President Ronald Regan in 1981. John Hinckley approached President Reagan as he left a Washington, DC, hotel following a speech President Reagan had just delivered. As Reagan walked out of the hotel, Hinckley fired six shots, hitting Reagan, Press Secretary James Brady, police officer Thomas Delahanty, and Secret Service agent Timothy McCarthy. Hinckley's defense team claimed he was obsessed with the movie *Taxi Driver* and the actress Jodie Foster. In the movie, Robert De Niro's character attempts to assassinate a presidential candidate. Hinckley's attempt to assassinate the President of the United States was intended to impress Ms. Foster and win her love. John Hinckley was ultimately found NGRI and remanded to St. Elizabeth's hospital in Washington, DC, where he continues to reside.

Hinckley's acquittal set off a firestorm of criticism of the insanity defense. Some called for a stricter standard to make it more difficult to be found insane, some called for the removal of the volitional prong of the *Brawner* rule and others called for a change in the burden of proof (Finkel, 1989). The **burden of proof** is the legal duty that one side or the other must fulfill in order to meet its case. In criminal trials the prosecution has the burden of proving the defendant is guilty beyond a reasonable doubt. As in all criminal trials up to this time, the prosecution had the burden of proof. In this case, they did not have to prove that Hinckley was guilty, but did have to prove John Hinckley was sane. Critics also wanted to reduce the **standard of proof** from the beyond a reasonable doubt standard to one of clear and convincing evidence or the less stringent preponderance of the evidence. Reducing the standard of proof, while continuing to require the prosecution to meet burden of proof, would also make it easier to find the defendant sane.

In 1984, the United States Congress passed the Insanity Defense and Reform Act (IDRA). The IDRA made it more difficult to be found insane in federal cases by

making four significant changes. It removed the volitional prong of *Brawner* and left the federal insanity standard, emphasizing cognitive and affective aspects. It also barred ultimate issue testimony from forensic psychologists and other mental health professionals. The burden of proof was placed on the defendant to prove he was insane. However, the standard of proof also was changed to clear and convincing evidence for the defendant. Clear and convincing is generally seen as easier to attain than beyond a reasonable doubt but more difficult to meet than preponderance of the evidence used in most civil trials (Goldstein et al., 2003).

Guilty but mentally ill

An alternative to insanity developed during the 1970s. In 1975, Michigan was the first state to establish a Guilty But Mentally Ill (GBMI) verdict after public concern arose over the release of insanity acquittees because of a Michigan Supreme Court ruling. In *People v. McQuillan* (1974), the Michigan Supreme Court ruled that individuals found NGRI had the same rights as patients who had been civilly committed. This ruling meant that NGRI acquittees had the right to have a hearing examining their dangerousness and the presence of mental illness. Because NGRI means that a defendant is acquitted of a charge based on his mental state at the time of the crime but not necessarily at the time of the trial, an insanity acquittee might be psychologically stable after a verdict had been reached and therefore released under this court ruling. As a result of *People v. McQuillan*, a hearing became required in Michigan immediately following any NGRI verdict to determine whether an individual was mentally ill and dangerous and should be civilly committed. The ruling resulted in the release of NGRI acquittees from mental hospitals in Michigan who were now judged to be no longer mentally ill (Mickenberg, 1987). However, two of these recently released individuals committed additional crimes soon after their release. One person, who admitted to 25 additional killings while institutionalized, kicked his wife to death 1 month after his release. The second individual committed two sexual assaults after his release (Mickenberg, 1987). Within months of the crimes and the enormous public outcry, Michigan instituted several laws designed to decrease the number of successful NGRI acquittals and increase the length of confinement for those found insane in the belief it would have a positive impact.

The GBMI verdict was part of the series of laws passed in Michigan to revise the insanity procedures. GBMI verdicts were not intended to replace NGRI but to give juries an additional option. In a case in which a defendant pleads insanity, the jury or judge can decide if the person is guilty, NGRI, or GBMI in the states that have allowed the option (Steadman et al., 1993). According to this standard, a defendant may be found GBMI if it is determined that (a) the defendant is guilty of the offense, (b) the defendant was mentally ill at the time of the offense, and (c) the defendant was not legally insane at the time of the offense. The intention of providing a GBMI verdict was to represent a middle ground between guilty and NGRI verdicts and to lessen the number of defendants found NGRI. Although a defendant found GBMI is subject to the same sentence as a defendant found guilty, the intent was that the defendant who

is found GBMI begins his sentence at a hospital where he receives treatment. Once treatment is complete, the prisoner is transferred to prison for the remainder of his sentence (Bumby, 1993; Savitsky & Lindblom, 1986). However, supervision of individuals found GBMI is even stricter in some states than for other convicted individuals upon release (McGraw, Farthing-Capowich, & Keilitz, 1985). Furthermore, it appears that individuals found GBMI do not receive special mental health treatment and several legal and mental health organizations have come out in opposition to GBMI laws because it allows juries to avoid confronting the issue of insanity and leads to antitherapeutic outcomes (Borum & Fulero, 1999). Nonetheless, the GBMI option remains available in about 20 states. Table 9.2 summarizes the changes to the insanity defense over the years.

Challenges to the Insanity Defense

Other states have gone even further in revising the insanity defense and abolished the option entirely. Four states have abolished the insanity defense, including Montana in 1979, Idaho in 1982, Utah in 1983, and Kansas in 1996 (Nusbaum, 2002). It is not completely clear how the abolishment of the defense has affected defendants in these states and whether it has led to more or fewer negative consequences. It may be that the respective systems find alternative mechanisms to address the needs of individuals who would otherwise be found insane. For example, the number of dismissals because defendants were found incompetent to stand trial substantially increased in Montana, with those defendants then frequently being civilly committed (Steadman, Callahan, Robbins, & Morrissey, 1989). These incompetent defendants could represent individuals who normally would have been found NGRI. Although the insanity defense has been technically abolished in these states, it appears that mentally ill individuals who have committed crimes may continue to be treated as if they were not responsible for their crimes and therefore the therapeutic impact may be negligible.

Clark v. Arizona (2006) is a case that confronted the Supreme Court with the potential for supporting or denying a constitutional right to the insanity defense. It had the potential to force those states that abolished the insanity defense to reinstate it. Specifically, the defense argued that Arizona had to include a provision for a cognitive element addressing the nature and quality of the act because its standard was very narrow without it, and that mental health testimony could be allowed for more than simply the issue of insanity. Ultimately, the Supreme Court did not directly address whether there was a constitutional basis for an insanity defense. The Court ruled that Arizona's standard for insanity, no matter how narrowly defined, was appropriate and that it was fully within the power of the state to limit expert testimony in insanity cases because of the potential for confusion among jurors. By not requiring a cognitive element to Arizona's definition of insanity, the Court reasoned that the issue would avoid unnecessary complexity introduced by more abstract expert testimony. Therefore, there continues to be no constitutional requirement for insanity. More recently, there was a case before the Supreme Court involving Joseph Dwelling, who attacked 3 people and killed 2 over the course of several weeks in Idaho. Dwelling's crime spree was brought on by

delusions that he had become Jesus; he later reported that he attacked his victims because they had tried to steal his "Jesus energy." Dwelling argued that he should be found insane and that he had a constitutional right to offer that defense, but Idaho has abolished it. If the Supreme Court had decided to review the case, it is likely that they would given a more direct ruling on the constitutional right to the insanity defense. Nonetheless, the Court refused to review the case and therefore it remains an open question.

Studies Assessing the Insanity Standards in Mock Jurors

Despite all the alterations in the criteria for the various insanity standards, research comparing the standards has shown they have little effect on juror verdicts. No significant differences in verdicts were found between mock jurors using either the ALI or *M'Naghten* standard (Ogloff, 1991) or between mock jurors applying the ALI or IDRA standard (Finkel & Slobogin, 1995). In the most comprehensive comparison of insanity standards to date, Finkel, Shaw, Bercaw, and Koch (1985) presented 132 undergraduates five cases, each of which dealt with a female defendant who was accused of killing someone with a pistol and who was invoking the insanity defense. The mental condition of the defendant varied for each case. Specifically, the defendant suffered from epilepsy, chronic alcoholism, paranoid schizophrenia, a stress-induced reaction, or experienced a split-brain commissurotomy. Participants were randomly assigned to apply one of six insanity standards (ALI, IDRA, wild beast, *M'Naghten*, *M'Naghten* plus the irresistible impulse, or the Disability of the Mind doctrine) to the five cases and to assign a verdict of guilty or NGRI. Results indicated no significant differences in verdict among the six insanity standards. This outcome was surprising given the differences in criteria among the standards and the range of restrictiveness previously discussed.

Although low comprehension of jury instructions provided in insanity cases may provide some explanation for the lack of verdict differences among the different insanity standards, other factors also may be influencing this outcome. One specific factor that has been examined is individuals' prior knowledge about insanity. In addition to the studies showing a lack of verdict differences among formal insanity standards, two studies have shown no differences in verdicts between mock jurors who were asked to apply formal standards and those who were given no formal standard (Finkel, 1989; Finkel & Handel, 1988). This finding suggests that the lack of verdict differences among insanity standards may be the result of individuals basing their decisions on their own naive standards, or schemas, rather than the formal insanity standards presented to them. Furthermore, these standards may even be more complex than any previously used standard of insanity (Finkel & Handel, 1989). Skeem and Golding (2001) asked subjects in a series of studies to identify the core features or prototypes of insanity. They also found that jurors understanding of insanity could not be reduced to the current legal standards, though the majority emphasized severe mental illness, a notion of moral insanity, and their mental state at the time of the crime. Wheatman and Shaffer (2001) suggest that actual deliberation of jurors may make a difference in variation across different

insanity standards though. Nonetheless, experts would be wise to consider jurors' conceptualizations of insanity when testifying.

Psycholegal researchers also have examined whether the availability of the GBMI verdict affects verdict outcomes in the intended way. Savitsky and Lindblom (1986) conducted the first GBMI study utilizing undergraduate students formed into six-person juries and exposed them to one of two videotaped trials. The mock jurors were given two verdict options (guilty, not guilty), three verdict options (guilty, not guilty, and NGRI), or four verdict options (guilty, not guilty, NGRI, and GBMI). Results indicated that a significant number of mock jurors shifted their verdict from NGRI to GBMI or that a greater number of defendants may be found guilty of the crime charged when the GBMI verdict option is available. Poulson (1990) found that the addition of the GBMI verdict choice had a twofold effect. Not only did the availability of GBMI decrease the number of NGRI verdicts, but it also decreased the number of guilty verdicts. Roberts, Golding, and Fincham (1987) further clarified this point by confirming that the addition of the GBMI alternative reduces the number of defendants found NGRI in cases exhibiting severe mental illness, and it reduces the number of defendants found guilty in cases of milder forms of mental illness. Therefore, it appears that the addition of the GBMI verdict choice can cause a verdict shift both from NGRI to GBMI and from guilty to GBMI depending on case specifics. Overall, the results clearly indicate that the presence of an additional verdict option in the form of GBMI influences jurors' decisions (Poulson, Wuensch, & Brondino, 1998). Whether jurors' selection of the GBMI verdict is due to the appropriateness of the verdict or the mere fact that it is an alternative verdict (i.e., a verdict other than guilty, not guilty, or NGRI) is unclear at this time.

Insanity Myths

As the previous section examining the influence of the different insanity standards seemed to suggest, there are a number of misconceptions regarding the insanity defense (Perlin, 1996). These misconceptions or myths typically focus on the overuse of the defense, severity of crimes at issue in these cases, severity of the mental illnesses involved, the disposition of insanity acquittees, and the dangerousness of insanity acquittees. The belief that the standard of insanity makes a significant difference in the rate of acquittals has been the focus of much of the public and legislative attention. This belief is based on the idea that the insanity defense is overused and abused by defendants. However, the available evidence suggests a very different picture. Though the rates vary between different jurisdictions, studies suggest that the insanity defense is rarely raised and even more rarely results in an acquittal. On average, the insanity defense appears to be raised in about 1% of all felony cases and is only successful about 26% of the time (Cirincione, Steadman, & McGreevy, 1995). However, there is significant variability and results are rarely comprehensive. For example, studies have been able to obtain usable data from 5, 7, 8, and 10 states respectively and have been largely confined to the most populous counties in those states (Callahan, Steadman, McGreevy, & Robbins, 1991; Cirincione et al., 1995; McGinley & Pasewark, 1989; Pasewark & McGinley, 1985). Furthermore,

these rates vary dramatically between states because of a number of unique differences in the procedures and laws. For example, Callahan et al. (1991) found that insanity plea rates varied anywhere from 0.30% to 5.74% of felonies cases and the acquittal rates varied anywhere from 7.3% to 87% in one state where it appeared that insanity pleas were largely entered via a plea arrangement between the prosecution and defense.

The 1% rate of insanity pleas and 26% of those ending in an acquittal are in clear contrast to the public perception (Silver, Cirincione, & Steadman, 1994). Table 9.3 shows these comparisons. Furthermore, there is a negative relationship between frequency of an insanity plea and its success ($r = -.67$) (Cirincione et al., 1995), so defendants in states that use the defense more frequently are less successful. It is clear that the public significantly overestimates both the use and the success of the insanity defense, but it may be possible to alter these beliefs. In one study, about 92% of community respondents believed the insanity defense was overused, but if educated about the actual rates, only 52% believed it was overused (Jeffrey & Pasewark, 1983). These data seem to suggest that much of the public concern over the insanity defense is due to a lack of knowledge about actual rates of use and success.

A second common misconception is that insanity acquittees are not severely mentally ill. In a study of over 1,700 pretrial defendants from federal courts, results found that 77% of those found insane were suffering from psychosis, a mood disorder, mental retardation, or an organic disorder and only 1% were malingering mental illness (Cochrane, Grisso, & Frederick, 2001). Callahan et al. (1991) found that almost 70% of insanity acquittees were diagnosed with some form of psychosis, an additional 16% suffered other major mental illnesses, and 4.8% were mentally retarded. Cirincione et al. (1995) further demonstrated that those individuals who suffered from a major mental illness were significantly more likely to be found insane than those without a major mental illness. Another study found that 84% of a random sample of NGRI acquittees over a 22-year span had a disorder involving a thought disorder or bipolar

Table 9.3. Public Beliefs and the Actual Insanity Defense

	Perception	**Actual**
Use of the insanity defense		
Percentage of insanity pleas	37%	1%
Percentage of insanity acquittals	44%	26%
Disposition of acquittees		
Percentage sent to mental hospital	51%	85%
Percentage freed	26%	15%
Conditional release		12%
Outpatient		3%
Release		1%
Length of confinement		
All crimes	22 months	33 months
Murder	–	76 months

Source: Adapted from Table 2 of Silver, Cirincione, & Steadman (1994)

disorder (McDermott et al., 2008). Research also indicates that the vast majority of insanity acquittees have been previously hospitalized for mental health reasons (Callahan et al., 1991, McDermott et al., 2008) and having at least one previous hospitalization was related to a successful insanity acquittal (Cirincione et al., 1995). Again, results suggest that public perception is inaccurate and that those who plea and are acquitted on the basis of insanity are severely mentally ill.

Another common misconception about insanity is that most insanity acquittals are charged with murder. Even attorneys believe that murder is the most frequently charged crime in insanity cases (Burton & Steadman, 1978). Cases in which people murder someone and then plead insanity are certainly the most memorable, but they tend to be the exception rather than the rule. Only 14.3% of insanity acquittals are charged with murder (Callahan et al., 1991) and someone charged with a violent crime other than murder is much more likely to receive an insanity acquittal than individuals charged with murder (Cirincione et al., 1995). Callahan et al. (1991) further identified that 38.2% of the insanity acquittees had been charged with a physical assault, 11.7% with other violent offenses, 7.4% with robbery, 18.0% with a property crime, and 9.9% with other minor crimes. McDermott et al. (2008) found a similar pattern of results.

One of the most significant misconceptions regarding the insanity defense is the disposition of insanity acquittals. Sales, Miller, and Hall (2005) stated that there are four approaches to the disposition of insanity acquittees across different jurisdictions. Someone found that NGRI either receives (1) no outcome and is free unless the jurisdiction attempts to civilly commit them separate from the criminal trial; (2) an automatic commitment hearing after the verdict has been rendered; (3) an automatic commitment for observation and evaluation that may last up to 30 to 60 days; and (4) an automatic civil commitment. The public generally believes that insanity acquittees are freed after their acquittal, but most states have provisions for immediate confinement, at least for evaluation purposes (Steadman et al., 1993). As Table 9.3 suggests, the public underestimates the percentage of insanity acquittees who are hospitalized by almost 35% and overestimates the percentage who are set free by almost 10%. However, if one eliminates the insanity acquittees who are conditionally released or released on an outpatient basis, the general public overestimates the number by an enormous difference. The public also overestimates the amount of time insanity acquittees are confined (Silver et al., 1994). In fact, it appears that insanity acquittees are institutionalized for as long as, or longer than, if they had been convicted of the original crime (Rodriguez, LeWinn, & Perlin, 1983; Silver, 1995), are hospitalized longer for more serious charges (Silver, 1995; Pasewark, Pantle, & Steadman, 1982), and unsuccessful insanity defendants are detained longer than felons who never raised the insanity defense (Braff, Arvanites, & Steadman, 1983). Silver (1995) even discovered that defendants who were found guilty were more likely to go free without ever being institutionalized than those found NGRI. Furthermore, the United States Supreme Court has not found anything inherently unfair about these potential disparities (*Jones v. United States*, 1983; *Foucha v. Louisiana*, 1992). As a result of some of these disparities, some states such as Virginia have begun to limit the length of hospitalization for insanity acquittees charged with misdemeanors. There are probably several reasons for the disparities in the lengthier institutionalization for insanity

acquittees (Zapf et al., 2006). Insanity acquittees tend to be individuals with severe mental illnesses for whom treatment has been largely ineffective over the course of their life. Dangerousness and mental illness are often linked with one another, though they are two separate requirements for continued detainment of insanity acquittees (*Foucha v. Louisiana*, 1992).

Another unique disposition for some insanity acquittees revolves around the particular crime they were excused for originally. Individuals found NGRI after committing sex offenses are increasingly registering as sex offenders under requirements from the federal Megan's Law, without ever having been convicted of a sex offense, though that is a requirement to be forced to register as a sex offender. Weiss and Watson (2008) list 23 states and the District of Columbia that have incorporated NGRI acquittees into their formal sex offender registration requirements. As a result, acquittees can be under supervision indefinitely if they commit a sexual offense. There is currently no available data to suggest whether sex offending insanity acquittees are at greater risk for reoffending than other acquittees.

There are often political realities that influence whether to confine insanity acquittees. For example, there is significant pressure from the public and political officials to never release two former clients of mine who were found insane after committing high-profile crimes. In one instance, the acquittee shot up a local nightclub and wounded dozens of people, murdering a law enforcement officer in the process. In the other instance, the individual murdered an entire family and sexually assaulted several members both before and after their deaths. Both of these crimes received huge media attention locally and the death of a law enforcement officer resulted in significant public and political pressure to keep these two individuals institutionalized each time they come up for release. Also, most jurisdictions do not have formal procedures for assessing risk and supervising the release of insanity acquittees, though there are models described in the literature (e.g., Bigelow, Bloom, Williams, & McFarland, 1999; Dirks-Linhorst & Linhorst, 2006). The divergence between the public's understanding of the disposition of insanity acquittees and actual practice is even more interesting when it becomes clear that insanity acquittees have no right to dispositional instructions in insanity cases (*Shannon v. United States*, 1994). This prohibition means that jurors cannot be instructed as to the dispositions or possible outcome of different verdicts they may reach. Courts fear that jurors will consider the disposition in deciding their verdicts, instead of focusing on the evidence before them.

Related to the dispositional outcome is the common misconception that insanity acquittees are especially dangerous once they are released. The general misconception about insanity acquittees is likely fueled by the media attention from incidents such as the murder and rapes committed by the released insanity acquittees in Michigan. However, there is the potential for actuarial formulas to predict future recidivism (McDermott & Thompson, 2006; Monson, Gunnin, Fogel, & Kyle, 2001). Nicholson, Norwood, and Enyart (1991) found in a sample of insanity acquittees that acquittees who escaped were much more likely to be arrested in the future than those who were discharged after completing treatment. Generally, the limited research on the subject suggests that the rate of recidivism for insanity acquittees is no greater than other felons.

Pasewark et al. (1982) found that recidivism rates for insanity acquittees were nearly identical (24%) when compared to felons (27%) from a small sample in New York. Kravitz and Kelly (1999) also found an even lower rate of recidivism among released insanity acquittees (16%). Furthermore, those acquittees who completed the treatment program were less likely to recidivate than those who had escaped from treatment, suggesting that civil commitment of insanity acquittees can reduce the chances of future recidivism (Nicholson et al., 1991), but Miraglia and Hall (2011) found that length of hospitalization itself was not associated with future arrests. As these individuals receive conditional releases to integrate back into the community, it is also important to design programs that are beneficial and identify those at highest risk (Vitacco et al., 2008). In their sample of conditionally released insanity acquittees, they found that only 7.11% had their status revoked because of a new offense, but those with antisocial personality disorder, a substance abuse diagnosis, and requiring short-term hospitalization were at greatest risk for revocation, thereby identifying potential targets for future interventions (Vitacco et al., 2008). See Box 9.2 for a full explanation of the study.

Box 9.2. Focus on Research: Designing an Intervention for Those Found Insane

States are increasingly attempting to prepare individuals found insane for return to the community while they are conditionally released and living in the community. These situations typically are difficult ones for policymakers because of the potential for violence and the public reaction. Vitacco et al. (2008) evaluated the factors that were related to poor outcomes among a group of these conditionally released individuals. Their sample consisted of insanity acquittees conditionally released in Wisconsin from 2000 through 2004, which consisted of 363 individuals. Acquittees in Wisconsin were released with significant support and a mandate to receive treatment and follow all conditions of their conditional release or be returned to the hospital. The majority (66.12%) of the sample were able to maintain their conditional release. Although 33.88% of the sample had their release revoked, only 7.11% had their release revoked for another offense with the remainder occurring because of some other violation (e.g., failure to take medication). In examining the variables potentially related to the revocation of a conditional release, the researchers found that gender, ethnicity, age, marital status, years of education, and living arrangements were all unrelated to a poor outcome. Being committed for a violent crime, sex offense, and even total number of offenses were also unrelated to poor outcome. However, the presence of substance abuse diagnosis and antisocial personality disorder were related to revocation releases, while a psychotic disorder diagnosis was not. Other variables that were related to the revocation of the conditional release were whether the individual needed a short-term hospitalization for stabilization and whether the individual was placed either under a high-risk or intensive supervision status upon release (compared to minimum and medium). A multivariate examination of these revealed that substance abuse, higher levels of supervision, and short-term hospitalization were all significant predictors of revocation release. Results suggest that treatment for substance abuse treatment, and predicting risk accurately, are imperative in making these decisions.

Evaluations of Insanity

Of all the different legal questions that forensic psychologists seek to assist the courts on, insanity investigations are among the more difficult for several reasons. First, the legal doctrine tends to be unclear. The nature of mental illness sufficient for insanity acquittals has been largely undefined by the courts. Furthermore, there have not been clear answers as to whether knowing the difference between right and wrong should emphasize a legal distinction, a moral distinction, or the level of impairment. Second, forensic evaluations are retrospective and require the forensic psychologist to reconstruct a defendant's mental state weeks or even months after the crime. This task often proves difficult because psychological assessment methods assess current mental health, but they do not allow the evaluator to travel back in time to assess someone's mental state precisely during the crime. Because of the retrospective nature of insanity evaluations, there also must be a greater reliance on third-party information. Although psychological measures do not allow for retrospective examinations, assessments of current mental functioning along with consultation with police reports, witnesses, and other prior records begin to offer a picture of most defendants. Fourth, there are no universally accepted interviews or psychological tests for insanity evaluations. Although we will discuss the two FAI used by some experts, there is a great deal of variability in forensic psychologists' approaches to insanity evaluations and they may exhibit less than ideal reliability as a result. Despite the challenges involved in conducting insanity evaluations, there are some common recommendations (Borum, 2003b; Goldstein et al., 2003; Melton et al., 2007; Rogers & Shuman, 2000a; Zapf et al., 2006).

Common Procedures for Insanity Evaluations

Insanity evaluations tend to consist of three major components similar to most forensic assessments: an interview, use of forensic related assessment instruments, and collection of third-party and collateral information (Zapf et al., 2006). However, there are not well established and empirically validated comprehensive approaches to conducting an insanity evaluation. Borum and Grisso (1996) surveyed forensic psychologists and psychiatrists asking about the elements central to an insanity report. Results revealed eleven different elements essential for a report: (1) psychiatric history, (2) current mental status, (3) formal mental status exam, (4) any current psychotropic medication, (5) psychological testing, (6) mental health records, (7) police information, (8) presence or absence of any prior diagnosis, (9) presence/absence and degree of any alcohol/substance abuse, (10) defendant's description of the offense, and (11) collateral description of the offense. Knoll and Resnick (2007) attempted to offer a model for evidence-based practice and made several recommendations, including identifying the primary objectives, standard procedures, the appropriate format for any report, and common errors found in insanity reports. Nonetheless, there is some evidence for the overall reliability and validity of insanity evaluations and some of the assessment approaches commonly utilized.

Reliability and Validity of Insanity Evaluations

There is little empirical information regarding the methods used in insanity evaluations. Research has generally suggested that mental health professionals rarely find a defendant insane, in contrast again with the public sentiment. Cochrane et al. (2001) found that only 12% of 719 referrals for insanity were found insane in a federal sample of offenders. In examining the decisions of clinicians, Murrie and Warren (2005) noted that most clinicians found between 5% and 25% of their insanity referrals insane. Mental health professionals also vary the percentage of insanity decisions according to the different standards in place, unlike the jurors who frequently decide these cases (Wettstein, Mulvey, & Rogers, 1991). Finally, the most important factor in insanity findings may be the ultimate decision of the expert (Steadman, Keitner, Braff, & Arvanties, 1983). As a result, it is very important to assess the reliability and validity of these decisions.

An examination of the reliability and validity of insanity evaluations is especially important because of the nature of the adversarial process. Brodsky (1991) and Rogers (1987) warned of the potential for forensic psychologists and other mental health professionals to become committed to a particular legal outcome or unintentionally mold their evaluation to the theory of the retaining attorney. Otto (1989) conducted an analogue study in which he examined the potential source of bias in insanity cases and found that expert testimony in these cases may vary according to the side that retained the expert. Advanced graduate students in a clinical psychology program were more likely to rate the defendant as guilty if retained by the prosecution and more likely to rate the defendant as NGRI if retained by the defense. However, this study used graduate students, not forensic psychologists or other fully trained mental health professionals, and the sample was small ($n = 32$). Beckham, Annis, and Gustafson (1989) did not find any bias attributable to the side that retained them among 180 forensic experts who evaluated a set of hypothetical case materials. However, Homant and Kennedy (1987) also found that in three separate studies, experts' political beliefs were related to their ultimate conclusions in a hypothetical insanity case.

Studies focusing on the reliability between raters have found high rates of agreement between them. Fukunaga, Pasewark, Hawkins, and Gudeman (1981) were able to examine 355 official cases in Hawaii. Courts typically appointed multiple independent evaluators to assess an insanity defendant. Examining these records, they found a 92% rate of agreement between the evaluators. However, it was unclear whether independent professionals communicated with one another prior to writing the report, potentially increasing the rate of agreement if they did collaborate. Overall, these high rates of agreement should not be surprising given that insanity verdicts are usually the result of an agreement between the defense and prosecution and rarely involve a trial and a battle of the experts (Melton et al., 2007). The cases that are likely to involve a contested trial are the ones that are less likely to involve clear cases either way and involve a host of unique characteristics likely to reduce consensus among experts (Zapf et al., 2006).

However, more recent research is challenging the early findings of high reliability between insanity raters. Gowensmith, Murrie, and Boccaccini (2012) examined sanity evaluations in Hawaii and found unanimous agreement in only 55.1% of the cases;

Stredny, Parker, and Dibble (2012) only found 78% in a sample of psychiatrists and psychologists. Gowensmith et al. (2012) did find that experts tended to diverge in their opinions when the defendant was under the influence of alcohol or drugs but agreed more when the defendant had a psychotic disorder or had been hospitalized immediately prior to the crime (Gowensmith et al., 2012). Beckham et al. (1989) also examined the characteristics related to decisions. Those experts who found the defendant guilty rated the defendant as displaying less schizophrenia at the time of the offense, judged the defendant's behavior as less likely a product of the mental illness, considered third-party information as more important, rated the clinical interview and some of the cognitive assessment data presented as less important, and had greater forensic experience (Beckham et al., 1989).

It is also problematic to study the validity of insanity evaluations because of the lack of a criterion measure or gold standard (Borum, 2003b). Typically, the decision of the evaluators is compared to the final verdict in these cases. However, the final verdict is influenced by the expert opinion; therefore, the criterion of the final verdict is biased in favor of the validity of these decisions. Not surprisingly, there is high agreement between the final verdicts in insanity cases and the judgments of the involved experts. Fukunaga et al. (1981) found 93% agreement between the expert conclusions and the final judgment. In a study of 143 defendants who pled the equivalent of NGRI in a metropolitan county for 1 year, there was 98% agreement between the evaluating experts opinion on the final verdict (Janofsky, Vandewalle, & Rappeport, 1989). The judges even followed the majority opinion in 91% of the cases in Gowensmith et al. (2012). The high rates of agreement also suggest that the so-called battle of experts is not the norm in insanity cases (Janofsky et al., 1989).

Forensic Assessment Instruments

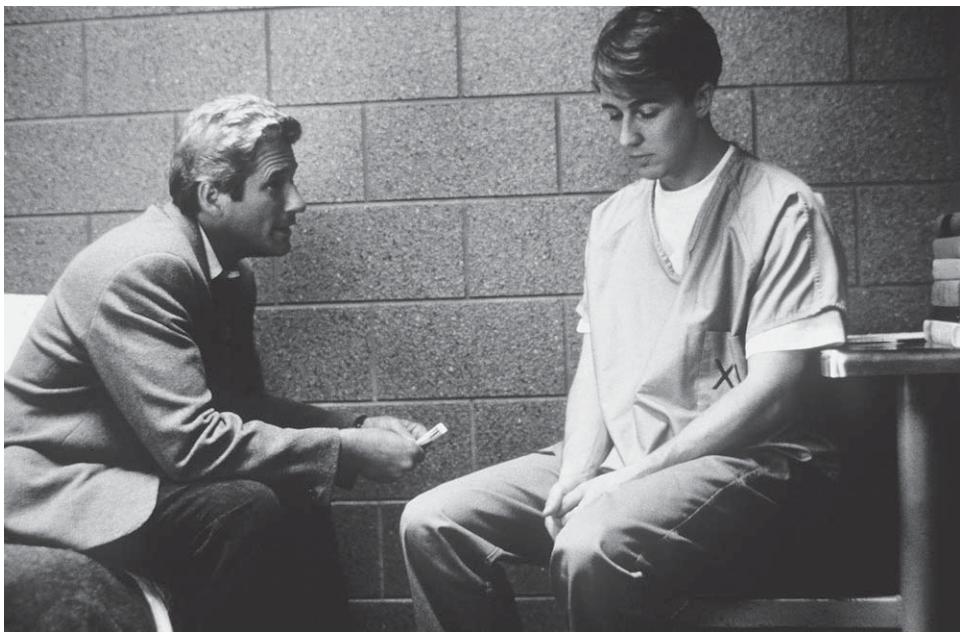
In order to improve upon the reliability and validity of forensic assessments, standard practice appears to be moving toward the use of forensic assessment instruments (Zapf et al., 2006). However, Borum and Grisso (1996) found that 46% psychologists never use FAIs in insanity evaluations with similar levels reported by Archer et al. (2006). Perhaps an explanation is the fact that there appears to be only one FAI available for use in assessments of insanity. Moreover, the reliability and validity of these instruments has been questioned and caution encouraged in using it (Melton et al., 2007; Rogers & Shuman, 2000b).

The evidence supporting the use of the Rogers Criminal Responsibility Assessment Scales (R-CRAS; Rogers, 1984) is growing. The R-CRAS is a 30-item measure intended to be used to standardize the information obtained from an insanity evaluation. Specifically, the R-CRAS was designed with the ALI criteria, but the author also recommends its use in jurisdictions using the *M'Naghten* standard. It also has items relating to GBMI verdict alternative (Rogers & Shuman, 2000a). The 30 items are divided into 5 components: patient's reliability, organicity, psychopathology, cognitive control, and behavioral control (Borum, 2003b). The R-CRAS does not dictate that

information on any of the relevant items be collected in a particular order or according to a specific set of questions. It is intended to be a tool to quantify or standardize insanity evaluations. Conclusions on the major criteria are then used to derive either a sane, insane, or no opinion overall conclusion. Though the interrater reliability for individual items is somewhat low, the five combined components demonstrate good reliability (Borum, 2003b). The summary ratings obtained from the R-CRAS also exhibit high rates of agreement (93% to 97%) with independent rater final decisions (Borum, 2003b). However, the R-CRAS has been criticized for the way in which it measures some of the items, emphasis on the ultimate issue, the quantification of judgment areas that are "logical and/or intuitive in nature" (p. 234), and unsupported scientific rigor (Melton et al., 1997). Rogers and Shuman (2000a) have accepted and addressed these criticisms but ultimately seem to conclude that the R-CRAS is better than any alternative and represents a significant step forward in the assessment of insanity, if used as part of a comprehensive evaluation.

Malingering and Insanity

Despite the use of some specialized measures for insanity evaluations, many people claim that insanity is easily malingered (Golding, 1992a; see Figure 9.1). Box 9.3 gives one famous example of an attempt to malinger by the Hillside Strangler. Given the secondary gain involved in insanity evaluations, the presence of malingering should



Rob Phillips/Paramount/Kobal Collection, Ltd., The Picture Desk

Figure 9.1. *Primal Fear* is a 1996 movie in which Ed Norton malingers dissociative identity disorder in order to be found insane for the murder of a priest. Richard Gere plays his attorney who is also initially fooled by him.

Box 9.3. A Lesson Regarding Insanity and Malingering: The Hillside Strangler

Kenneth Bianchi and his cousin, Angelo Buono, were dubbed the *Hillside Strangler* after a series of rapes and murders of young women in the Los Angeles area during 1977 and early 1978. Victims were typically raped, tortured, and strangled to death with their bodies often being dumped on hillsides around Los Angeles. The media and law enforcement originally suspected it was only one killer and it was not until well into the investigation that law enforcement officials realized it was likely two men. After he was apprehended, Bianchi decided to plead insanity based on the belief that he suffered from multiple personality disorder or, as it is now called, dissociative identity disorder. He reportedly got the idea from the movie *Sybil* and blamed the murder on Steve Walker, the name given to his altered personality.

Though two experts originally believed Bianchi suffered from dissociative identity disorder, two additional experts concluded that Bianchi was faking, or malingering, the disorder. There were several indications that Bianchi was malingering the disorder. One clue was uncovered by the police when they discovered that Bianchi had used the name of a student, Steve Walker, to obtain a college diploma fraudulently so he could practice psychology. Also, while Bianchi was pretending to be Steve Walker, he slipped several times and referred to Steve as "he" instead of "I." In addition, Dr. Martin Orne was able to trick Bianchi during his clinical interview of him. Dr. Orne was an expert in determining whether people were truly hypnotized and during his attempt to hypnotize Bianchi, he determined that Bianchi met several criteria for someone who is actually not hypnotized. Orne also purposely misled Bianchi by telling him that people who suffer from dissociative identity disorder have more than one additional personality. Soon after an additional personality named Bill surfaced, with two others soon following. Eventually, Bianchi agreed to testify against Buono, though he was very uncooperative during the trial itself. He is now serving multiple life sentences.

always be considered. However, there is insufficient evidence to conclude that insanity acquittees are successfully feigning mental illness or neuropsychological impairments at significant rates. Cochrane et al. (2001) identified only one individual in over 700 federal insanity referrals who was diagnosed with malingering, though more subtle exaggeration and defensiveness are likely. Nonetheless, forensic experts should remain on alert for potential signs of malingering such as those identified in Chapter 2. There also are a number of standardized measures designed to assess for the presence of malingering. Some measures mentioned in Chapter 2 are arguably better (SIRS-2) than others (MMPI-II) in the detection of malingered psychopathology. Forensic psychologists should also make sure to focus on both the exaggeration of psychopathology and cognitive and neuropsychological impairments with standardized measures (Rogers & Shuman, 2000a). Rogers and Shuman (2005) even go so far as to say that expert testimony on malingering that does not involve a standardized measure probably does not fulfill the *Daubert* criteria.

Other Issues of Criminal Responsibility and Diminished Capacity

Besides insanity, there are a number of additional issues related to criminal responsibility and diminished capacity that include automatism, diminished capacity, and intoxication. In each of these instances, there is a negation of mens rea, a term we discussed earlier. The negation of mens rea leads to a reduction in criminal responsibility but normally not a complete excuse for it. Empirical support for forensic practice in these areas is even more sparse than for insanity defenses (Clark, 2006). The role of the forensic psychologist continues to be similar in terms of the assessment of a defendant's mental state at the time of a given crime, though the application of that expertise to more ambiguous legal notions becomes even more complex and more difficult.

Automatism recognizes there are criminal acts that may occur involuntarily. Traditional examples typically include a defendant who lacks full consciousness because she is sleeping, experienced a head injury, or suffers from epilepsy or dissociation. There tend to be three differences between insanity and automatism (Melton et al., 2007). Insanity requires a mental illness and automatism does not. The prosecution typically has the burden of negating automatism defense, whereas the defense has the burden of proof in insanity cases. Insane persons generally have conscious control of their behavior, though they may lack awareness of the nature or cannot stop themselves, but the very nature of automatism is that it occurs involuntarily or unconsciously. Automatism tends to be rarely invoked. Furthermore, if a person has a history of a related disability, it is often presumed that the defendant should have done something to prevent the crime (Melton et al., 2007).

The second notion, **diminished capacity**, was introduced by the California Supreme Court (*People v. Wells*, 1949). A claim of diminished capacity allows a defendant to introduce testimony regarding his mental status without claiming insanity that focuses directly on his mens rea. This claim can be potentially beneficial when the relevant criminal charge includes a specific intent element that the defendant had to knowingly or purposefully commit an act. For example, a defendant may be charged with first-degree murder that requires he knowingly or purposely killed someone. A diminished capacity defense could potentially negate the mens rea element and only allow a conviction on a lesser offense, such as manslaughter, that only requires the defendant to have acted recklessly or negligently, not purposefully or knowingly. Although as many as 15 states have used some form of diminished capacity (Weiner, 1985), the concept has been criticized and fallen out of favor (Clark, 2006). Part of the reason for this trend was the involuntary manslaughter conviction of Dan White after his 1978 shooting of the mayor of San Francisco and a city supervisor. This trial is noteworthy not only because of the effect it had on the diminished capacity defense but also because it is the source of the so-called "Twinkie defense" (Clark, 2006). A defense expert testified at the trial that Dan White suffered from manic depression, now called bipolar disorder, and that it was partially worsened by his repeated binges on junk food and Coke, specifically Twinkies. However, there is not a specific Twinkie

defense. In fact, Ewing and McCann (2006) devote a chapter to debunking the myth of the Twinkie defense in their book, *Minds on Trial*.

Although **intoxication** can be the basis of an insanity defense, an automatism defense, or diminished capacity, voluntary intoxication also can be raised in most states as a reason for failure to exhibit sufficient mens rea for crimes that require the defendant exhibit the behavior purposely or knowingly (Melton et al., 2007). In this situation, the person is not aware that her consumption of alcohol or some other drug may impact her behavior and increase the risk of perpetrating a particular crime. This defense also may apply to involuntary intoxication where someone's drink is spiked or even chronic intoxication. The defense may similarly apply to someone who suffers from a mental illness and fails to take his medication. However, the law on the use of intoxication is very incoherent and lacks consistency across different jurisdictions (Clark, 2006).

Reflection and Review

1. What is the reason for the existence of the insanity defense? Does this reason seem valid?
2. Should we be concerned about the specific legal standard for insanity?
3. What are some of the myths surrounding the insanity defense? What are some of the realities for the myths?
4. Should there be a legal requirement for insanity to be a possible defense in all jurisdictions?

Key Terms

ALI standard	diminished capacity	*M'Naghten* standard
automatism	*Durham* rule	product rule
Brawner rule	intoxication	standard of proof
burden of proof	irresistible impulse test	wild beast test

Further Readings

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10 Domestic Violence and Stalking

Chapter Objectives

1. Describe the different ways domestic violence can occur
2. Identify the consequences of domestic violence
3. Describe the risk assessment process within the context of domestic violence
4. Identify the additional issues related to criminal responsibility and diminished capacity
5. Explain the treatments for domestic violence
6. Describe the nature of stalking and the inaccurate perceptions surrounding it

As domestic violence increasingly enters the court system, forensic psychologists are subsequently being asked to assist the courts. Forensic psychologists are performing several roles in domestic violence cases and are specifically being asked to

> (1) Describe the nature, frequency, severity, and consequences of previous violence; (2) make predictions about the likelihood and severity of future violence; (3) provide intervention recommendations for the batterer as well as for the victim; and (4) make predictions regarding the likely outcomes of these interventions. (Levensky & Fruzzetti, 2003, p. 713)

This chapter will focus on the aspects of domestic violence, which are very much in keeping with assessment and treatment in forensic psychology in general. However, domestic violence presents numerous challenges to forensic psychologists working in the area.

Before we begin, there are a couple of important issues to clarify. Most of the research in this area has focused on male-perpetrated domestic violence, and this chapter will

be no different. However, the research examining women as perpetrators of domestic violence and some of the potential differences in male- and female-perpetrated domestic violence will be considered, along with some of the societal implications. The ways in which the law plays a role in the practice of forensic psychology and the mental health of those involved is profound in domestic violence. The impact is evident not only near the disposition and trial stage, as has been the case for much of our discussion so far, but also in the arrest or initial reporting of domestic violence. In addition, we will discuss a topic that is related to domestic violence, stalking. Though we know relatively little about stalking in comparison to domestic violence, the area has significantly expanded in terms of clinical practice and research over the past decade.

Defining and Identifying the Prevalence of Domestic Violence

As with risk assessment and general violence, it is important to define the nature of domestic violence. Domestic violence can mean any violence or aggression perpetrated within the context of a significant interpersonal relationship (e.g., family, marriage, dating). Domestic violence encompasses psychological, physical, and sexual aggression between intimate partners. Domestic violence could include violence between a husband and a wife, a girlfriend and boyfriend, or gay and lesbian partners. It could include violence between parents and children (see Chapter 12 for a discussion of child abuse), between adult children and elderly parents, or even between siblings. However, this chapter will focus on domestic violence that occurs between men and women in intimate partner relationships. Also, domestic violence between couples goes by a variety of names, including *interpersonal violence* or *intimate partner violence*, so be aware of those terms if you are searching the literature on the topic.

Factors That Influence Prevalence Figures

As a partial result of the definition and way in which we measure domestic violence, there are not definitive prevalence rates. Some estimates suggest that as many as one-third of all women are victims of domestic violence during their lifetime (Straus & Gelles, 1990) and that 4 million women each year are assaulted by a partner (see Sartin, Hansen, & Huss, 2006). However, these statistics should be examined cautiously in terms of their purpose and definitions of domestic violence. Did they include psychological aggression? Were the studies assessing members of the community, or a high-risk group of people? Are they estimates, or more precise numbers arrived at thorough empirical research? For example, one review found that lifetime rates varied anywhere from 1.9% in a sample from Washington state to 70% among Hispanic Latinas in the Southeast (Alhabib, Nur, & Jones, 2010). Alternatively, many studies only include violence occurring in the last year. Moreover, some studies include only physical violence, while others include both physical and psychological violence in their definition of domestic violence. There are very important empirical considerations in assessing the prevalence of

domestic violence and then using those findings to inform the courts or put certain behaviors in an appropriate context.

Studies examining couples who are living together or are married also have found varying rates of domestic violence. Straus and Gelles (1990) telephoned about 2,000 couples and found that approximately 12% of women reported they had been victims of physical aggression in the last year by their partner, with 5% reporting being the victim of severe violence in the last year. Moracco, Runyan, Bowling, and Earp (2007) reported lifetime rates of domestic violence and found 23.4% of women had experienced physical violence and 14.3% sexual violence. However, studies examining **clinical samples** of men and women have found much higher rates of domestic violence. In a sample of 132 couples coming to a marital therapy clinic, 53% of the women were victims of physical aggression by their husbands and 21% were victims of severe aggression (O'Leary, Vivian, & Malone, 1992). In another study, couples who sought psychological treatment for marital difficulties reported that 71% experienced at least one episode of aggression in the last year (Cascardi, Langhinrichsen, & Vivian, 1992). It should not be surprising that clinical samples of marital couples include higher rates of domestic violence than **community samples**. Clinical samples are composed of individuals who are seeking treatment either for domestic violence or marital problems, or mental health issues in general. One of the major findings of a comprehensive review of all prevalence studies was that prevalence rates were highest among studies conducted in psychiatric settings and emergency rooms. By contrast, prevalence rates were lowest among college students (Alhabib, Nur, & Jones, 2010). It is much more likely that those individuals presenting for psychological or physical treatment will report domestic violence than those drawn from the community at large. In fact, 50% to 70% of couples who seek therapy for marital problems also experience physical aggression in their relationships (Feldbau-Kohn, Schumacher, & O'Leary, 2000).

Another potential problem with assessing domestic violence harkens back to our discussion of general risk assessment, the manner in which domestic violence data is collected. Because domestic violence is associated with an intimate partner, the perpetrator and victim of the violence are often available and prevalence data may be available from both parties. Nonetheless, victims and perpetrators are reluctant to give accurate reports of domestic violence (Heckert & Gondolf, 2000), especially in certain contexts. For example, only 6% of women indicated that domestic violence was a problem in their marriage when responding to a written self-report. However, 44% admitted it occurred during an interview and 53% using a questionnaire (O'Leary et al., 1992). Not only may domestic violence be underreported using certain methods, but victims report more violence than perpetrators (Cantos, Neidig, & O'Leary, 1994; Simpson & Christensen, 2005).

Domestic violence figures are also gathered through criminal justice statistics, which may give us different prevalence rates. There were 588,000 crimes reported in 2001 that were perpetrated by intimate partners (Rennison, 2003). However, criminal justice figures are dependent on someone getting involved in the legal system and many avoid difficulties that would arise for them and their partner in the legal system, as indicated by the finding that only about 7% of domestic assaults and 14% of severe domestic

assaults are ever reported (Kantor & Strauss, 1990; Straus & Gelles, 1988). Nonetheless, in 1 year 1,247 women and 440 men were killed by their intimate partners. These figures constituted 33% of all female murder victims but only 4% of all male murder victims (Rennison, 2003). No matter the source of the prevalence data on domestic violence, it is clear that it is significant problem.

Assessment of Domestic Violence among Intimate Partners

One of the most common tasks for a forensic psychologist in this area is to assess the severity and frequency of any domestic violence in a relationship and the potential for future risk. This assessment could be necessary to assist a judge at arriving at a criminal sentence or educate a batterer program that may be providing court-ordered treatment. Despite the intricacies of defining the prevalence of domestic violence, the Conflicts Tactics Scale (CTS) (see Table 10.1 for a partial list of the items) has become the standard measure for domestic violence among intimate partners (Langhinrichsen-Rohling, 2005), allowing for a common comparison across studies that had previously been lacking. Not only does the CTS assess intimate partner violence, but it does so in a way that suggests additional meaning to the behavior. The CTS suggests that domestic violence occurs within a marital conflict and even assesses positive behaviors that involve negotiation (Langhinrichsen-Rohling, 2005). The revised CTS, CTS2, contains items that assess the severity of the injury the victim experiences and any sexually coercive behavior. Nonetheless, the CTS has been criticized (Schafer, 1996). It was initially condemned because studies using it suggested equal rates of perpetration for men and women (Archer, 2000). As a result, it was criticized for ignoring the context in which domestic violence occurred such as out of self-defense or fear of being struck first. The CTS also has been criticized for assessing a limited number of specific acts and not identifying the entire range of aggressive incidents (Levensky & Fruzzetti, 2003). However, the original author of the CTS has replied to these and other concerns. See Box 10.1.

Table 10.1. Examples of Psychological, Physical, and Sexual Violence Derived from the Conflict Tactics Scale

Psychological violence	Physical violence	Sexual violence
Insulted	Kicked, bit, or punched	Used force or threats to have sex
Swore at	Slapped	Insisted on sex without protection
Yelled at	Beat up	Used threats or force to have anal sex
Stomped out of a room	Twisted arm	Insisted on anal sex
Threatened to throw something	Pushed or shoved	Insisted on sex
Destroyed their belongings	Choked	
Did something to spite	Slammed against a wall	
Accused of being poor lover	Used a knife or gun	
	Burned or scalded	

Box 10.1. Focus on Research: Straus's Reply to the Conflict Tactics Scale (CTS) Controversy

The controversy surrounding the CTS and the CTS2 is a good lesson for forensic psychologists to be aware of the literature regarding any method or specific tool they use in their practice and the potential professional disagreements that ensue. Although the CTS is the most widely criticized measure of domestic violence, it is also the most widely used. To address the criticisms directly, Straus (2012) published a paper in *Behavioral Sciences and the Law*. He identified criticisms that he believed were both valid and "erroneous" (Straus). Straus believes that methodological limitations of the CTS are not driving the criticisms of the instrument, but that theoretical and values disagreements are the guiding force. He believes that a theoretical issue is that studies using the CTS have been the ones primarily suggesting equal rates of perpetration between men and women and thereby contradicting the major theoretical explanation for domestic violence, a patriarchical theory that men perpetrate domestic violence against women to maintain their control over women. Straus further points to studies using the CTS that have actually supported this feminist theory and results using the CTS in keeping with the victimization of women are routinely accepted, while those focused on perpetration by women are questioned. In regard to values, Straus poses the question whether we are more concerned about ending domestic violence or ending violence against women and takes the stand that he is most concerned with ending domestic violence. He argues that perpetration by women is part of the context of domestic violence and it is important to consider it. Otherwise, it has the potential to undermine efforts to reduce any domestic violence, no matter the perpetrator. Whether the opponents' claims are correct or Straus's defense is correct, it is an important lesson that empirical research and the practice of psychology are not necessarily free from bias and that external forces can play a role in our understanding of the empirical literature. Ultimately, it is important for the forensic psychologist to be aware of the potential limitation of any instrument he or she uses and any controversy surrounding it.

Assessing Consequences of Domestic Violence

In assessing domestic violence, not only does a forensic psychologist attempt to assess the frequency and severity of the violence but it is also important to assess the consequences to the victim. By assessing the consequences, a clinician is beginning to identify potential interventions to reduce the suffering of the victim. There have been a wide variety of identified consequences of domestic violence. The impact can be partially exemplified in a Bureau of Justice Statistics report that indicates 1.4 million people were treated in hospital emergency departments for injuries confirmed or suspected to have resulted from interpersonal violence (Rand & Strom, 1997). Almost 250,000 of these patients were victimized by a spouse/ex-spouse or boy/girlfriend (Rand & Strom, 1997). Cascardi et al. (1992) have specifically documented the significant physical injuries and negative psychological symptoms suffered by victims of domestic violence who

have presented to outpatient marital therapy clinics. In addition to the physical effects of domestic violence, there are also a number of psychological consequences that forensic psychologist have the expertise to actually assess and inform the courts about.

Psychological Consequences of Domestic Violence

One of the most prominent psychological consequences of domestic violence is post-traumatic stress disorder. Posttraumatic stress disorder (PTSD) is a psychological disorder, identified in DSM-IV TR, characterized by exposure to a traumatic event or series of traumatic events. This exposure can result in avoidance of any stimuli associated with the traumatic experience, reexperiencing of the trauma, dreams, increased arousal, or emotional numbing. These types of symptoms overlap significantly with Lenore Walker's construct of battered woman syndrome (BWS; Walker, 1979), though Walker's construct also suggests a basis for certain characteristic behaviors that are not part of PTSD but quite common among women suffering from BWS (e.g., failing to leave an abusive relationship despite the continued abuse). Unfortunately, PTSD appears to be a common psychological outcome for domestic violence, but findings vary widely between studies (Houskamp & Foy, 1991; Kemp, Green, Hovanitz, & Rawlings, 1995; Riggs, Kilpatrick, & Resnick, 1992). Golding (1999) found that in 11 studies examining the prevalence of PTSD among victims of domestic violence, 63.8% of women suffered from PTSD.

Victims of domestic violence also exhibit high rates of depression. Research has found that battered women exhibit depression levels similar to psychiatric patients and have much higher rates than individuals who have not been victims of abuse. Furthermore, the severity of the depression relates to the severity and frequency of the violence (Mitchell & Hodson, 1983). A review of these studies found that between 38% and 83% of women in abusive relationships exhibited depression (Cascardi, O'Leary, & Schlee, 1999). Stark and Flitcraft (1988) even estimated that battered women were at five times greater risk for a suicide attempt than women who were not in an abusive relationship. Depression and substance abuse often co-occur in a variety of groups and battered women are no different. The Golding (1999) meta-analysis also found that 18.5% of battered women experienced alcohol abuse and 8.9% suffered from drug abuse. Sato and Heiby (1992) have gone beyond simple prevalence rates of depression and found that women who reported poor self-reinforcement, personal and financial losses, and a past history of depression were at significant risk for depression because of the violent relationship.

A final major psychological consequence of domestic violence is its impact on self-esteem. Studies have consistently found reduced self-esteem among battered women compared to non-battered women and other comparison groups (Aguilar & Nightingale, 1994; Holtzworth-Munroe, Smutzler, & Sandin, 1997; Mitchell & Hodson, 1983). In addition, a negative association between severity of abuse and whether the abuse began prior to the marriage or not has been found (Clements, Sabourin, & Spiby, 2004). Furthermore, lowered self-esteem is related to both physical abuse and psychological abuse (Aguilar & Nightingale, 1994).

These consequences though are not only the result of the physical violence the victim experiences. In general, people often believe physical abuse leads to many of the severe consequences of domestic violence. Although O'Leary (1999) concluded this belief is probably true about the most severe violence experience by victims, it is not necessarily correct in regard to most of the violence experienced in intimate relationships. Studies suggest that psychological abuse has more severe long-term psychological effects than most physical abuse and that the psychological abuse normally occurs prior to the physical abuse (O'Leary, 1999). Even victims of domestic violence believe psychological abuse is more damaging to them. One study found that the majority of women from abusive relationships believed that psychological abuse had a greater impact than physical abuse and that psychological abuse occurred more frequently (Follingstad, Rutledge, Berg, & Hause, 1990). In fact, Murphy and Cascardi (1993) suggested that many of the psychological consequences of abuse may be the result of the psychological rather than physical abuse, as had been previously thought.

No matter the cause or the precise psychological difficulties experienced by the victim as a result of the abuse, forensic psychologists are often called upon to assess the extent of the consequences. Besides using clinical interviews and measures like the CTS/CTS2 to assess the domestic violence directly, these assessments also include measures to assess the psychological consequences of the abuse. The severity of the consequences may give insight into the severity and overall pattern of the abuse. This information is of course relevant in treating the victim, but it is also relevant in assisting the courts to arrive at an appropriate disposition for the perpetrator of domestic violence whether it be incarceration, treatment, or a combination of both.

Risk Factors and Risk Assessment in Domestic Violence

In addition to identifying the prevalence and consequences of domestic violence, another important role for forensic psychologists is to assess the risk for domestic violence. Although we will discuss many similarities between assessing risk for domestic violence and for other forms of violence discussed previously, there are also several aspects unique to domestic violence that any forensic psychologist should be aware of when conducting risk assessments. Unlike other forms of violence previously discussed, the victim may be repeatedly available to the perpetrator, increasing the opportunity for victimization. Should the punishment of the perpetrator be based on the continued presence of the victim? The issue of risk management becomes extremely important because of victim availability. As we will discuss, there are a variety of dynamic risk factors that can influence the perpetration of domestic violence and with the easier access to victims, identification of those factors and designing interventions specifically to reduce them or their impact is extremely important.

Because of the continued presence of the victim, many experts also encourage consideration of the victim's perceptions of the assault cycle and risk factors. However, these factors should be considered cautiously because victim perceptions may be biased. For example, one of the most important determiners of continued contact between a

perpetrator and victim is if the perpetrator seeks out treatment. Women are more likely to stay with a batterer who seeks out treatment than one who does not. Given the significant dropout rates and moderate treatment effects for domestic violence programs, a significant increase in the woman's sense of safety simply because the batterer is seeking treatment could be problematic. Nonetheless, research is increasingly suggesting that victim perceptions are integral to risk assessments for domestic violence (Heckert & Gondolf, 2004).

Risk Factors for Domestic Violence

Much of the research has focused on identifying risk factors related to the onset of domestic violence. Furthermore, these risk factors have largely examined physical violence at the exclusion of psychological violence or sexual violence. Though there are some differences between studies depending on the sample and the availability of different factors, these factors can be grouped into demographic and historical factors, psychological factors, and relationship factors.

Demographic and historical factors

Demographic and historical factors have long been recognized for their relationship to the onset of domestic violence. Reviews of the literature suggest that the perpetrator's age, socioeconomic status of the perpetrator, race, and childhood exposure to domestic violence form complex relationships with the onset of domestic violence (Feldbau-Kohn et al., 2000; Holtzworth-Munroe, Smutzler, & Bates, 1997). Although earlier reviews suggested that there was no relationship between age and domestic violence perpetration (Hotaling & Sugarman, 1986), later reviews indicate otherwise (Feldbau-Kohn et al., 2000; Holtzworth-Munroe, Smutzler, & Bates, 1997). These results have been demonstrated continuously in large national studies and are generally in keeping with the literature on the perpetration of generalized violence. Findings consistently suggest that age is inversely related to the perpetration of domestic violence so that the younger the perpetrator, the greater the risk for domestic violence. In a study focusing on almost 12,000 men enlisted in the military, the authors found that for every 10 years age increased, the risk decreased by 19% that a man would perpetrate mild violence and 29% for severe violence (Kantor, Jasinski, & Aldarondo, 1994). These age-related results hold true even when other demographic variables are considered (Kantor et al., 1994).

Socioeconomic status (SES) demonstrates a similar negative or inverse relationship with the perpetration of physical violence in domestic violence conflicts. Furthermore, the most severe levels of aggression appear to be related to lower socioeconomic status (Hotaling & Sugarman, 1990). Socioeconomic status is usually a global variable comprised of multiple variables such as employment status, annual income, education level, and living above or below poverty that indicate overall wealth. Although domestic violence occurs at any economic level, the lower the SES, the greater the risk for the perpetration of domestic violence (Holtzworth-Munroe, Smutzler, & Bates, 1997). This

relationship is continually found for a number of reasons. Individuals from low SES backgrounds are more likely to suffer from a variety of financial and other interpersonal stressors that increase their risk for domestic violence. Individuals from lower SES backgrounds are also likely to be less educated. Less educated individuals are less likely to seek out professional assistance and less likely to know where to turn for professional assistance when they are in troubled relationships. Because SES is a global variable comprised of many different variables, studies may or may not find a relationship between some of the isolated variables that compose SES. Nevertheless, the relationship between global SES and domestic violence is fairly consistent.

Race and ethnicity also have been related to domestic violence perpetration. Similar to the relationship between SES and domestic violence, there may be some specific racial and ethnic relationships that increase the risk for domestic violence, even though domestic violence cuts across all racial and ethnic groups. Most of the research, as well as many of the largest studies, have found significant differences in the perpetration of domestic violence comparing Whites with African Americans and Hispanics or Latino Americans. Research has found higher rates of domestic violence in African Americans (Cazanave & Straus, 1990), Hispanics (Straus & Smith, 1990), and non-Whites in general (Leonard & Blane, 1992). In two large national studies, researchers found that prevalence rates for African Americans and Latinos were approximately 17% compared to 12% for Whites in the same studies (Straus & Gelles, 1986; Straus, Gelles, & Steinmetz, 1980). Studies have even found that African Americans are at higher risk for reoffending after initial instances of domestic violence (Mears, Carlson, Holden, & Harris, 2001). However, research has clearly shown that there are a host of other variables that account for these racial and ethnic differences such as economics, education, and social networks (Holtzworth-Munroe, Smutzler, & Bates, 1997). For example, Benson, Wooldredge, Thistlethwaite, and Fox (2004) found that domestic violence rates vary for African Americans and Whites systematically depending on their community of origin and that racial differences largely disappear when different racial groups reside in similar communities. Even though research may suggest a relationship, it is important to realize that other factors account for these apparent racial differences.

A final historical variable that is related to domestic violence perpetration is exposure to domestic violence in one's family of origin. Generally, men who grow up in abusive and violent homes as children are more likely to perpetrate domestic violence. The notion of intergenerational transmission of violence has long been a staple of the domestic violence field (Rosenbaum & Leisring, 2003). **Intergenerational transmission of violence** means that individuals who were exposed to violence as children are more likely to perpetrate violence in their own families as adults. These results are true whether one was physically or verbally abused themselves or witnessed the abuse between others (Barnett & Fagan, 1993; O'Leary & Curley, 1985; Widom, 1989). Mitchell and Finkelhor (2001) even found a 158% increase in the risk for violence if exposed to parental violence as a child. This cycle of violence is self-perpetuating in that individuals who have been abused are also more likely to abuse their own children, who are then more likely to abuse their children.

Psychological characteristics related to domestic violence perpetration

There are a host of psychological characteristics that have demonstrated some association with the perpetration of domestic violence such as jealousy, need for power and control, and reduced assertiveness (see Feldbau-Kohn et al., 2000, for a review). However, research has suggested that there are some psychological characteristics that are more strongly related to the perpetration of domestic violence than others.

One of the most prominent and intuitively appealing psychological characteristics related to domestic violence is the expression of anger or hostility. Although feminist theories for the perpetration of domestic violence are wary of focusing on anger, anger and hostility are often at the core of treatment strategies designed for domestic violence perpetrators. Dutton, Starzomski, and Ryan (1996) compared domestic violence perpetrators and a control group of men on a variety of measures and found that domestic violence perpetrators reported more anger. Hanson, Cadsky, Harris, and Lalonde (1997) further found that anger and hostility scores on a self-report measure differed significantly between severely abusive men, moderately abusive men, and nonabusive men. These trends also have been identified across studies using both clinical samples and community samples and were identified as moderate to strong factors for the expression of physical violence (Schumacher, Feldbau, et al., 2001; Stith, Smith, Penn, Ward, & Tritt, 2004).

In contrast to the long-standing interest in anger and hostility, there is growing interest in the role of substance use and substance abuse in the perpetration of domestic violence (Thompson & Kingree, 2006). Drugs and alcohol have been associated with domestic violence both in terms of chronic abuse and use immediately prior to or during a domestically violent episode. Studies using self-report questionnaires have clearly found that alcohol- and drug-related problems increase the risk for domestic violence (Cunradi, Caetano, Clark, & Schafer, 1999; Hanson et al., 1997). Moreover, risk also increases with immediate use, not simply chronic use. On days in which the perpetrator consumes alcohol, the risk is eight times higher that he will physically assault his partner (Fals-Stewart, 2003), and alcohol consumption is more common in severe violence (38%) than moderate violence (11%) or verbal violence (3%) (Leonard & Quigley, 1999). Accordingly, treatment programs are increasingly examining the impact that substance abuse treatment can have on the perpetration of domestic violence (O'Farrell, Fals-Stewart, Murphy, & Murphy, 2003).

A final psychological characteristic often associated with domestic violence perpetration is depression. At first glance, depression may be counterintuitive to violent behavior, but the field is relatively unanimous in finding that perpetrators are more likely to have elevated levels of depression (Stith et al., 2004). Men presenting themselves for marital therapy with their partner differed in their levels of depressive symptoms with maritally violent men reporting more depression than nonviolent men (Boyle & Vivian, 1996). In one study, nearly two-thirds of the domestic violence perpetrators were depressed compared to only one-third of the rest of the sample (Maiuro, Cahn, Vitaliano, Wagner, & Zegree, 1988). Depression may be related to a heightened display of emotion that is characteristic of at least some batterers (Holtzworth-Munroe & Stuart, 1994). These batterers are likely to exhibit borderline tendencies, exhibit heightened levels of depression, and express more suicidal ideas and behavior (Dutton, 2002).

Relationship and contextual factors related to perpetration

Another extremely important area to consider for potential risk factors is the relationship itself. Individuals who are unhappy or dissatisfied with their relationship, frequently argue with their partner, and demonstrate psychological aggression are at increased risk for the perpetration of domestic violence (Feldbau-Kohn et al., 2000). There are even specific communication patterns that suggest increased risk (Holtzworth-Munroe, Smutzler, & Bates, 1997). In fact, relationship factors may be among the best predictors of domestic violence (Stith et al., 2004).

It is not surprising that couples report less satisfaction with abusive relationships than nonabusive relationships, but it is important that marital satisfaction of the perpetrator is itself predictive of violence toward his partner. There appears to be a clear association between violence and relationship dissatisfaction. Julian and McKenry (1993) found a significant predictive relationship between reported relationship satisfaction and self-reported violence in a group of men presenting for treatment. However, the evidence for a predictive relationship between marital satisfaction and violence is not as clear. The question becomes one of the chicken versus the egg. Does the violence decrease marital satisfaction or does decreased marital satisfaction lead to violence? Results from one of the few longitudinal studies addressing the issue suggests a more complex relationship. O'Leary, Malone, and Tyree (1994) found that marital dissatisfaction after 18 months of marriage did not predict later physical aggression. However, marital dissatisfaction at 18 months predicted psychological aggression, which predicted physical aggression at 30 months after marriage.

Self-reported marital satisfaction may be as important as the communication patterns couples exhibit with one another. This research has focused both on observational studies of couples and interviews. In many studies, couples are videotaped discussing their relationship or problems in their relationship. Researchers later observe these interactions in detail and identify several aspects of these conversations that increase the risk for future physical violence. Husbands who exhibit physical aggression are more likely to dismiss their partner's opinion, threaten or mimic their gestures, become defensive, and use negative physical contact than verbally aggressive husbands (Margolin, Burman, & John, 1989; Margolin, John, & Gleberman, 1988). Studies examining self-report data also have found that violent couples are more likely to use more verbal attacks, more anger, and are more likely to withdraw from the situation (Lloyd, 1990).

Other characteristics related to domestic violence perpetration

In addition to these routine aspects of intimate relationships, there also appears to be some risk factors that are less intuitive. Specifically, there are two events that significantly increase the risk for relationship violence. First, evidence suggests that pregnancy significantly increases risk for domestic violence and that a significant number of women begin to be victimized during pregnancy (Jasinski & Kantor, 2001). Another period of time during the relationship that is especially dangerous for women is at the ending of the relationship. One study showed the end of an intimate relationship to be the most dangerous time for women because their partners become threatened by a clear indication of a change or loss in the relationship (Wilson, Johnson, & Daly, 1995).

So far we have focused on physical aggression in identifying factors related to domestic violence. However, as already discussed, there are a variety of forms of domestic violence, including psychological aggression, sexual aggression, and even the most severe consequence, homicide. Very few studies have identified the risk factors for sexual abuse in domestic violence situations. Black, Heyman, and Slep (2001) reviewed the available studies and found several risk factors for sexual abuse. Victims under 30 and over 50 who come from low SES backgrounds, were sexually assaulted outside of the relationship, and have experienced severe physical aggression in general are at greater risk (Black et al., 2001). Although more difficult to predict than physical violence, Schumacher, Slep, and Heyman (2001) concluded that relationship variables such as the communication patterns previously described along with perpetrator characteristics (i.e., anger, borderline personality characteristics, passive–aggressive characteristics, and self-defeating characteristics) indicated higher risk for psychological abuse. Surprisingly, SES and witnessing violence as a child were unrelated to psychological abuse in a relationship.

An area of increasing concern is the occurrence of homicide in domestic violence relationships. For example, **femicide** is the leading cause of premature death for women in the United States (Greenfield et al., 1998). Research suggests that there are unique as well as consistent risk factors for cases of homicide. A history of domestic violence and the presence of a handgun appears to be the strongest risk factors for intimate partner homicide, with the ending of a relationship also serving as a strong predictor (Campbell, Sharps, & Glass, 2001). In addition, generalized violence, alcohol abuse, unemployment, and being a member of a racial minority are significant risk factors for homicide (Campbell et al., 2001). One of the most comprehensive studies of intimate partner homicide was conducted across 11 cities and included information from 220 female victims. Results showed that relationships in which the perpetrator had access to a gun, the perpetrator made prior threats with a weapon, the perpetrator's stepchild was in the home, and the parties were separated were at greater risk. Never living together and prior domestic violence arrests were protective factors for homicide (Campbell et al., 2003).

Assessing Risk and Recidivism

In addition to those factors related to the onset of domestic violence, research has also focused on factors related to recidivism. Hilton and Harris (2005) argue that the most relevant risk factors are general antisocial behavior, psychopathy, substance abuse, a history of assault, and psychological abuse in the relationship. Cattaneo and Goodman (2005) agreed with some of Hilton and Harris's review but also focused on additional interpersonal (e.g., length of time lived together) and systemic factors (e.g., stake in conforming their behavior to societal expectations) that are relevant to domestic violence recidivism. Examinations of risk factors specifically for recidivism are relatively recent and a great deal of research is needed to assess these factors in comparison to factors related to the onset of abuse. However, several measures have been devised based on the general risk factor literature and the literature focusing on recidivism. Nonetheless, information regarding the effectiveness of these measures is only beginning to accrue.

Risk assessment and risk assessment measures for domestic violence

As mentioned previously, there are several aspects of risk assessment within domestic violence that are similar to general risk assessment, but there are also differences because of the nature of domestic violence. Whittemore and Kropp (2002) identified five principles of risk assessment that forensic psychologists should be aware of in a domestic violence context. First, they recommend that risk assessment should consider risk factors supported in the literature. This recommendation is in keeping with general risk assessment and possible because of the growing literature on risk factors for domestic violence. Second, they recommend that domestic violence risk assessments should use multiple sources of information. Not only is this recommendation in keeping with the overall risk assessment literature, but it also is consistent with the focus of assessment described in Chapter 2 and the importance of converging evidence. Therefore, an interview with the defendant, review of police records, and interview with the victim are strongly encouraged. Whittemore and Kropp (2002) pay special mention in the third principle to making sure risk assessments are victim-informed. This step is especially important if the perpetrator and victim plan on continuing their relationship or must associate with one another because they share children. Given that perpetrators also may be less than truthful, victims represent a good source of information. Fourth, Whittemore and Kropp (2002) recommend that risk assessments should lead to risk management. They argue that safety plans and other interventions should be individually designed to best address the dynamic risk factors (e.g., substance use) unique to a specific individual. Finally, risk assessments can be improved by using specific measures or guidelines. Though the research on these risk assessment instruments for domestic violence is minimal, findings to date suggest benefits to using these approaches for domestic violence as well as generalized violence.

There are nearly a dozen different measures available for the assessment of domestic violence (Dutton & Kropp, 2000; Hilton & Harris, 2005; Langhinrichsen-Rohling, Huss, & Rohling, 2006; Roehl & Guertin, 1998). It is beyond the scope of the current chapter to examine all of them. However, it is important to identify four of the measures that are somewhat distinct in their method and purpose. The Spousal Assault Risk Assessment (SARA) guide is a structured approach to risk assessment for domestic violence recidivism (Kropp, Hart, Webster, & Eaves, 1998). The Domestic Violence Risk Appraisal Guide (DVRAG) is an actuarial approach when there is a significant amount of information available for a risk assessment. Two additional measures have been developed more recently for use by frontline staff instead of clinicians. The Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER) is intended for use when time is limited. The Ontario Domestic Assault Risk Assessment (ODARA) is an actuarial approach to the assessment of domestic violence recidivism when less in-depth information is available and can be used by a variety of law enforcement and mental health professionals (Hilton, Harris, & Rice, 2004).

The SARA is a 20-item structured approach to the assessment of domestic violence risk (Kropp et al., 1998) and is similar to other measures such as the HCR-20 that score each item on a 0–2 point scale. The authors of the SARA claim that the 20 items

are derived from the literature and represent the most significant risk factors for spousal assaults. They recommend interviews with the defendant and the victim as well as review of all available collateral records to score the SARA. The measure can be used to assess risk by examining the total score, the number of items present, or the number of critical items present. There are only a handful of empirical studies examining the reliability and validity of the SARA (Grann & Wedin, 2002; Heckert & Gondolf, 2004; Kropp & Hart, 2000; Williams & Houghton, 2004). Generally, these studies have found modest associations between scores on the SARA and domestic violence whether examining prospective or retrospective violence. The SARA has equaled or outperformed other measures of domestic violence (Heckert & Gondolf, 2004; Williams & Houghton, 2004). The B-SAFER is the counterpart to the SARA and is a 10-item measure intended for use by police and other non–clinically trained individuals. The evidence supporting its use is very preliminary at this point (Au et al., 2008; Thijssen & Ruiter, 2011), but promising.

The ODARA, in contrast to the SARA and B-SAFER, is an actuarial measure devised using a strict statistical approach in identifying the items (Hilton et al., 2004). There are 13 items that make up the ODARA and it is designed so that front-line personnel (e.g., probation officers) can easily use the measure. There is little published research examining the ODARA to date but early results are promising. The ODARA correlated significantly with several other domestic violence risk assessment measures and independent raters could consistently code the measure. The ODARA outperformed the SARA and the DAS and demonstrated an ability to predict domestic violence recidivism similar to measures designed to assess general violence risk (Hilton et al., 2004). The DVRAG also is an actuarial measure but includes additional items that necessitate a trained clinician. Again, validation research is early in development but the tool shows some potential for use in assessing future risk of domestic violence (Hilton, Harris, Rice, Houghton, & Eke, 2008; Rettenberger & Eher, in press). The empirical support for any of these measures is limited and clinicians should be cautious in employing them. They should not be the sole basis for any domestic violence risk assessment at this time but they do hold promise.

Domestic Violence Treatment

As more and more attention has been focused on domestic violence, we have continued to search for interventions and treatment approaches designed to decrease and eliminate the problem. More than any other topic discussed so far, successful reduction of domestic violence likely depends on a multimodal approach. A multimodal approach requires that we use multiple types of treatment and intervention approaches. These approaches should include traditional psychological approaches, involvement of the community, and involvement of the criminal justice system. No single approach is likely to eliminate the problem, but focused simultaneous efforts may make a significant difference in the lives of thousands of people.

Educational and Psychological Treatment

The standard approach to reduce domestic violence has been programs focused on treating the perpetrators of domestic violence. These programs have traditionally been based on a feminist model for the perpetration of domestic violence. The feminist model is exemplified in the most prevalent treatment approach for domestic violence perpetrators, the Duluth Model. The Duluth Model proposes that the cause of domestic violence is the continued subjugation of women by men and that domestic violence is another attempt to control women. The Duluth Model tends to be confrontational and challenges the perpetrators' notions of power and control over their female partners. Figure 10.1 shows the "power and control wheel," which is based on the Duluth Model of treatment. In contrast to the Duluth Model, cognitive-behavioral therapy (CBT) programs focus on cognitive-behavioral principles discussed in Chapter 2. CBT programs focus on anger management and on identifying the thought patterns or cognitive distortions that are likely to lead to the anger and violence in these relationships. These thought patterns may be based on issues of power and control but also tend to focus on much broader issues that are reflected in the domestic violence. The CBT approach also applies equally to men or women as perpetrators of domestic violence. Either one

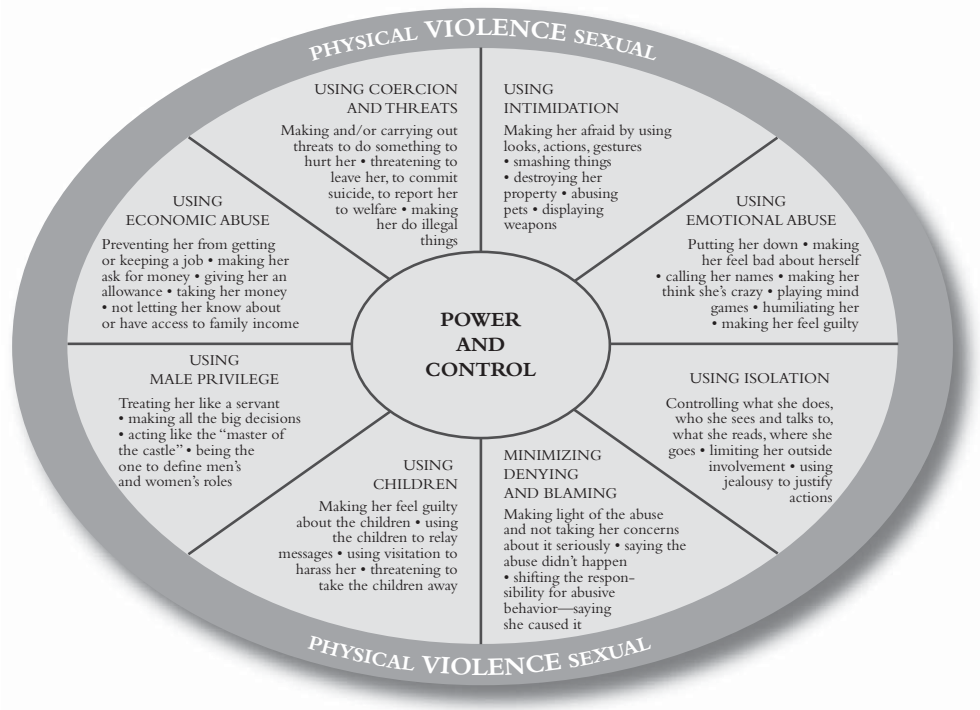

PHYSICAL VIOLENCE SEXUAL
USING COERCION AND THREATS
Making and/or carrying out threats to do something to hurt her • threatening to leave her, to commit suicide, to report her to welfare • making her do illegal things
USING INTIMIDATION
Making her afraid by using looks, actions, gestures • smashing things • destroying her property • abusing pets • displaying weapons
USING ECONOMIC ABUSE
Preventing her from getting or keeping a job • making her ask for money • giving her an allowance • taking her money • not letting her know about or have access to family income
USING EMOTIONAL ABUSE
Putting her down • making her feel bad about herself • calling her names • making her think she's crazy • playing mind games • humiliating her • making her feel guilty
POWER AND CONTROL
USING MALE PRIVILEGE
Treating her like a servant • making all the big decisions • acting like the "master of the castle" • being the one to define men's and women's roles
USING ISOLATION
Controlling what she does, who she sees and talks to, what she reads, where she goes • limiting her outside involvement • using jealousy to justify actions
USING CHILDREN
Making her feel guilty about the children • using the children to relay messages • using visitation to harass her • threatening to take the children away
MINIMIZING DENYING AND BLAMING
Making light of the abuse and not taking her concerns about it seriously • saying the abuse didn't happen • shifting the responsibility for abusive behavior—saying she caused it
PHYSICAL VIOLENCE SEXUAL

Figure 10.1. The power and control wheel is used to depict the causes of domestic violence. It follows from the Duluth model of treatment, which is based in a feminist perspective that sees patriarchal society as the reason for domestic violence. Adapted from: Michigan.gov

of these models tends to use a group-based approach that typically lasts anywhere from 12 to 52 outpatient sessions. Perpetrators are usually court-referred to these programs as a condition of their sentence. A forensic psychologist may be involved in leading one of these groups, conducting intake evaluations to determine appropriateness for the groups, or providing progress reports to the court in order for it to make further legal determinations.

The available research assessing the effectiveness of domestic violence treatment programs for men is mixed. Early reviews of the literature questioned the effectiveness of men's programs, especially in comparison to men who were arrested and either refused treatment or never completed treatment (Rosenfeld, 1992). Some experts even suggested that treatment programs put women at risk because women have a false sense of security when their partners attend treatment (see Holtzworth-Munroe, Beatty, Beak, & Anglin, 1995). A more recent meta-analysis by Olver, Stockdale, and Wormith (2011) even showed greater rates of recidivism by domestic violence perpetrators (37.8%) than offenders across all programs (27.1%) and offenders in sex offender programs (27.6%). Another meta-analysis attempted to address whether batterer treatment works and whether either of the two most prominent treatment approaches were superior. Babcock, Green, and Robie (2004) examined the available studies evaluating treatment of male batterers and found the treatment approach (CBT or Duluth) did not significantly impact treatment outcome and that treatment had minimal impact on recidivism. However, the authors compared the results involving male batterers to other interventions to put their findings in context. For example, although batterer treatment is far less effective than psychotherapy in general, it is as effective as or superior to similar psychological interventions such as those that focus on criminal offenders (Babcock et al., 2004). Moreover, even the modest treatment effects indicated in their meta-analysis would mean that over 40,000 women each year were no longer abused (Babcock et al., 2004).

Research has focused on batterer typologies in order to better understand the etiology of domestic violence and to improve treatment (Holtzworth-Munroe & Stuart, 1994). Holtzworth-Munroe and Stuart (1994) proposed a batterer typology that consisted of three groups of batterers: family-only, borderline/dysphoric, and generally violent/antisocial. The family-only batters, who constitute 50% of all batterers, were largely believed to confine their violence to the family and be free of mental illness or psychopathology. Holtzworth-Munroe and Stuart (1994) suggested that borderline/dysphoric batterers constitute 25% of batterers and exhibit elevated levels of depression, anger, substance abuse, and general emotional dysregulation. The generally violent/antisocial batters are likely to be more violent outside the family, exhibit more severe violence within the family, and demonstrate general antisocial characteristics. Research has supported this typology or grouping of batterers (Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2000; Langhinrichsen-Rohling, Huss, & Ramsey, 2000), but research has largely failed to examine treatment differences between the different groups of batterers. However, the available evidence does suggest that there may be treatment differences between these types of batterers and that interventions could be designed to address more effectively the different batterer types (Huss & Ralston, 2006; Saunders, 1996).

In addition to batterers receiving psychological treatment, treatment for domestic violence often focuses on the female victims and couples. The focus of treatment for the victims of domestic violence is often on the psychological consequences of the violence, avoidance of self-blame, and educating the victim about available options, both legal and otherwise (Guyer, 2000). Psychological treatment focuses on treating the trauma symptoms characteristic of PTSD as well as depression, anxiety, and low self-esteem that have resulted from the abuse. Therapy can take the form of individual or group-based treatment for the female victims. Another controversial form of treatment is conjoint or couples therapy. Many are concerned that couples therapy is dangerous for the female victim because she may be abused for statements she makes in therapy or be afraid to be open and honest because of the presence of the batterer. As a result, it is recommended that couples therapy only occur in situations in which the victim feels comfortable and is not in ongoing physical danger from the batterer (Feldbau-Kohn et al., 2000). The advantage of couples therapy is that the couple can work on the interaction patterns that are precursors to the abuse. However, there is no clear evidence that either couples or individual therapy is superior (Feldbau-Kohn et al., 2000), although there is evidence that couples treatment can be effective (O'Leary, Heyman, & Jongsma, 1998; O'Leary, 2008).

Community-Based Interventions

There are a variety of potential community-based interventions that are an integral part of domestic violence treatment (Sullivan, 2006). These interventions include safe houses, shelters, and advocacy programs. Safe houses are unpublicized or secret locations where victims of abuse can seek out temporary shelter from their abuser and relocate. Shelters tend to be more long-term solutions that offer therapy. These programs not only assist the adult victims but may also provide shelter and assistance for any children who are equally likely to suffer the effects of living in an abusive environment (O'Leary & Woodin, 2006). Advocacy programs offer the assistance of a professional advocate who assists the victim with obtaining resources to reestablish a life outside of the abusive partnership and identify the legal mechanisms that may be available for ending the abuse. These different programs not only allow for the safety of the victim but also encourage victims to make safety plans and get the long-term assistance needed for their recovery. Forensic psychologists may work in these settings providing services directly or recommending these services for victims of domestic violence during the assessment process.

Criminal Justice Interventions

There are several ways the criminal justice system can have a therapeutic or anti-therapeutic impact on the lives of batterers and victims of domestic violence (Simon, 1995). There has been great debate about whether the most effective intervention for batterers is incarceration or psychological treatment. However, the impact of the criminal justice system extends beyond incarceration of the perpetrators. As mentioned

previously, the best approach for the reduction of domestic violence is a multimodal one. An approach that focuses on the integration of psychological and educational interventions, community-based interventions, and the involvement of the criminal justice system is most likely the best solution. Some even argue that focused domestic violence courts are the best approach.

One of the first criminal justice interventions designed especially for domestic violence situations was the use of **mandatory arrests**. Mandatory arrest policies require law enforcement officers to arrest one party when they arrive at a scene where domestic violence is suspected. Officers have no discretion in these situations but to arrest at least one of the parties. Mandatory arrest policies were originally praised because some believed that many law enforcement officers used to try to de-escalate the immediate situation but failed to recognize that the victim would be in danger after the officer left. For example, the victim is potentially at increased risk because the police were called and the perpetrator may be further aggravated because of it. The victim also may turn the officers away when they arrive because she decides not to pursue any charges because of promises from the abuser, only to be assaulted when the officers leave. As a result, mandatory arrest policies were derived to reduce the risk to the victim and increase the likelihood of a conviction. Early evaluations of these policies were promising and found therapeutic outcomes. Sherman and Berk (1984) found that arrested subjects exhibited less violence upon follow-up. However, more extensive follow-up studies have not found the same results and have even found that mandatory arrest policies may result in an increase in violence (Sherman, 1992). Even though the effectiveness of mandatory arrest effects are mixed, a promising approach has been the creation of special domestic violence victims unit or specialized training for law enforcement officers to learn how to better deal with these situations. These efforts, much like domestic violence courts, increase the attention and resources directed toward prevention of domestic violence.

Another legal intervention commonly used in domestic violence cases is the implementation of restraining orders or protective orders. A **protective order** or order of protection is a legal document that makes certain levels of contact between the victim and the perpetrator illegal. For example, a protective order may require a perpetrator to stay 1,000 feet away from the victim on pain of arrest. **Restraining orders** also are issued by the court to protect someone but may also include provisions for property, child support, and child custody during a divorce or separation. These orders can be temporary or permanent. However, evidence suggests that the majority of perpetrators violate them within 1 year (Dobash & Dobash, 1979; Wardell, Gillespie, & Leffler, 1983) and that the offenders who exhibited more severe abuse are more likely to violate the orders. Despite the violation of these orders, Logan, Walker, and Hoyt (2012) found that protective orders saved taxpayers over $85 million in one small state during a single year. Simon (1995) suggests that when judges act in a neutral manner and encourage the perpetrators to commit to the order, they are more likely to be effective. Though the criminal justice interventions have not met with unanimous empirical support, greater awareness by the criminal justice system is part of the solution in addressing the problem from a multimodal approach.

Gender Differences in the Perpetration of Domestic Violence

As is apparent from our discussion in this chapter, the bulk of the research has focused on men as perpetrators of domestic violence and women as victims. However, there is increasing research to suggest that this view is simplistic and may be incorrect (Holtzworth-Munroe, 2005). The debate over the gender differences in the perpetration of domestic violence is evident in some of the early ground-breaking research of Straus and colleagues. They found equal or greater perpetration of domestic violence by women compared to men (Straus et al., 1980; Straus & Gelles, 1988). The focus on female-perpetrated domestic violence is evidenced in the increased attention and development of perpetrator typologies focused on women (Babcock, Miller, & Siard, 2003) and treatments for female perpetrators (Leisring, Dowd, & Rosenbaum, 2003). However, the reports of female-perpetrated violence conflict with feminist theory, reports of female victims, and the results of crime surveys (Archer, 2000).

Proponents of the feminist theory have suggested several alternative explanations for the numerous studies finding equal or greater prevalence of female perpetrators. Some have argued that the use of the CTS and the failure to consider these acts in their context exaggerated female-perpetrated violence. For example, they argue that women are more likely to act in self-defense, less likely to inflict harm, and more likely to report domestic violence. It has also been suggested that the differences may arise from the samples studied. Most feminist researchers tend to study samples of women who have suffered high levels of violence such as those in shelters, whereas other research has focused on more representative community or partner samples (Johnson, 1995). A meta-analysis of previous studies suggested that the sample differences may account for some of these differences but also found that women perpetrate physical aggression equally but inflict less severe injuries (Archer, 2000).

Much of the research supports some of these explanations for the apparent gender equality in the perpetration of domestic violence. Although community samples suggest equality of perpetration and marital therapy samples are more likely to include bidirectional violence (Vivian & Langhinrichsen-Rohling, 1994), men appear to inflict much greater injury (Busch & Rosenberg, 2004) and women are more likely to suffer psychologically from the abuse. These results suggest support for a distinction between domestic violence and **battering**. Domestic violence may be bidirectional and largely include less severe physical violence. Battering tends to be characterized by the most severe forms of violence, significant psychological abuse, issues of power and control, and some of the social and financial inequalities between men and women that make it more difficult for women to leave the abusive relationship. For example, a batterer may force his victim to eliminate all contact with her friends and family. She may be a homemaker or work only part-time and therefore be financially dependent on him. She may also be the primary caregiver for the children and therefore even further dependent on him. All of these aspects make it more difficult for battered women to leave these relationships than someone who is involved in bidirectional violence. These

battered women are then more in need of the services of shelters, safe homes, and advocates than women involved in bidirectional violence.

There are very few direct comparisons of male- and female-perpetrated violence. However, Melton and Sillito (2012) examined a sample of men and women who had been reported to police as perpetrators of domestic violence in a large metropolitan area during a single year. The majority of the sample was indeed men (87%), but it could be argued that these cases should be more similar because they all had risen to the level of needing police intervention. Nonetheless, there were some differences between men and women in this sample. Men were more likely to have evidence of prior perpetration, were more likely to have scared victims, were less likely to be present when law enforcement officers arrived, were less likely to give conflicting statements, and were more likely to engage in stalking. There were no differences between male- and female-perpetrated violence in regard to the use of threats, verbal abuse, use of alcohol/drugs, violence during the incident, injuries, or the action taken by the police. Studies like this one suggest there are some important differences between male- and female-perpetrated domestic violence whether general prevalence rates from community samples are relatively similar or not.

Stalking

Another issue that has received considerable attention in recent years, but not always immediately associated with domestic violence, is stalking. Stalking is defined in a variety of ways but is commonly defined by the legal statutes that criminalize it. For example, Nebraska's Statute (2004) reads that "any person who willfully harasses another person with the intent to injure, terrify, threaten, or intimidate commits the offense of stalking." Similar statutes are seen in all 50 states in the United States. Although most people associate stalking with well-publicized celebrity occurrences such as with David Letterman and Madonna and some even argue the impetus for the widespread anti-stalking laws was the murder of a celebrity at the hands of her stalker (Box 10.2), these instances tend to be extremely rare. Experts calculate that there are 1.4 million victims of stalking each year in the United States (Tjaden & Thoeness, 1998) and almost all of these victims are not celebrities.

So, if the overwhelming majority of stalkers do not fit the mold we see publicized in the media, what do they look like? Most stalkers appear to have a previous intimate relationship with their victim (Palarea, Zona, Lane, & Langhinrichsen-Rohling, 1999). Meloy (2000) and Zona, Sharma, and Lane (1993) have even gone so far as to suggest theoretical subtypes of stalkers, based on Meloy's considerable forensic experience with them, that consists of three types of stalkers: simple obsessional, love obsessional, and erotomanic. Meloy argues that about 65% of stalkers are simple obsessional and are characterized by a prior relationship between the victim and the perpetrator. He argues that these stalkers are also more likely to commit more violence toward persons and property. Love obsessional stalkers do not tend to have a prior relationship but have thoughts about a potential future relationship or attraction. These stalkers tend to be

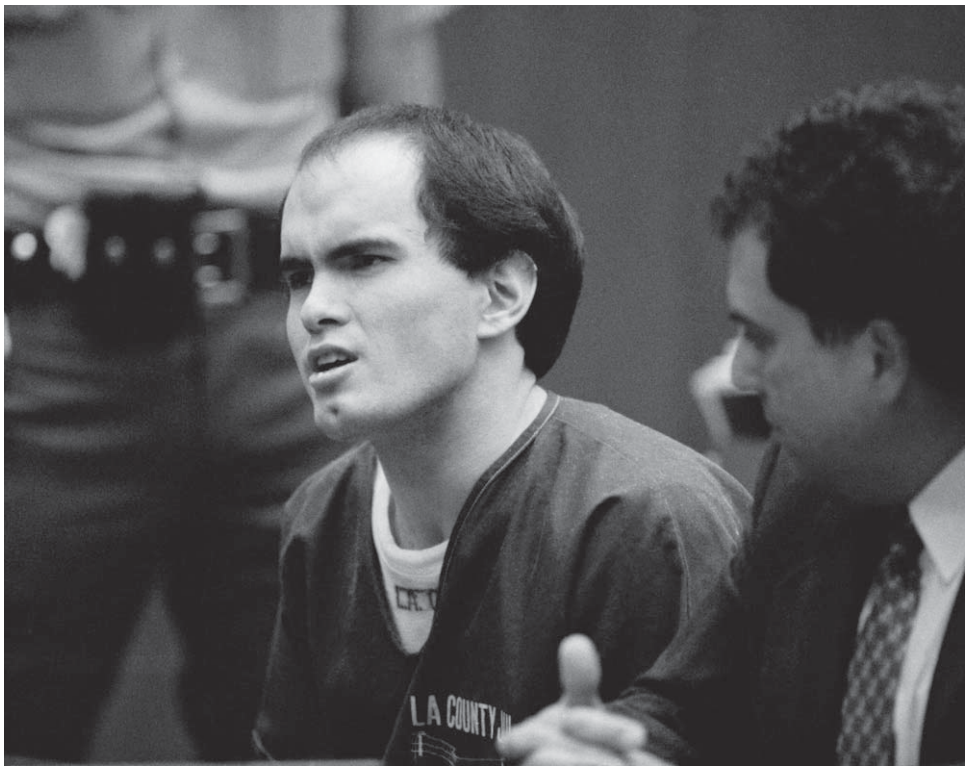
Box 10.2. Celebrity Stalkers from *My Sister Sam* to David Letterman

When most people think of stalkers they tend to think of high-profile celebrity stalkers and the extreme measures they take to express their obsessive tendencies toward their victims. For example, Madonna was stalked by a man who scaled the wall of her home, threatened to cut her throat, and came within feet of her. David Letterman was stalked by a woman who continually broke into his Connecticut home, stole his car and claimed to be his wife when stopped by a law enforcement officer, and was arrested for shoplifting near his mother's house in Indiana. However, one of the original celebrity stalking cases that ended tragically but contributed immensely to the public and legal awareness about stalking occurred in 1989.

Rebecca Schaeffer was the star of a short-lived sitcom in the 1980s called *My Sister Sam* and was seen as an up and coming young star in Hollywood before she was murdered. Schaeffer's killer, Robert Bardo, began stalking her by writing her letters as any other fan would. He even showed up at the gates of the studio where *My Sister Sam* was being taped with roses and a teddy bear but was turned away. The stalking escalated though when he showed up at the studio again with a concealed knife, but was once again denied entry. He then started to write Schaeffer love letter after love letter, collected videos of all of her television appearances, plastered his room with her picture, and made comments to his friends and family that if he could not have her, then nobody would. He became relentless in his mission to meet her, doing such things as calling her agent for her address, walking the streets of Los Angeles asking random passersby if they knew where the woman in the picture he showed them lived, and finally he successfully hired a private detective to get her address. Bardo showed up at Schaeffer's apartment and rang the bell of her apartment building entrance one fateful day. The intercom in her apartment was not working so she came down to the entrance where Bardo handed her a picture expressing his admiration of her. Schaeffer asked him to leave but he later rang the buzzer again and hid so she could not see that it was him until she opened the door. When she did open the door, Bardo shot her in the chest twice and walked away. Schaeffer's tragic death is frequently identified as one of the impetuses for legislation designed to prevent stalking and for formation of a special Los Angeles Police Department unit focused largely on stalking.

the least dangerous, according to Meloy (2000), and constitute about 25% of stalkers. The final type of stalker is the erotomanic stalker, who is characterized by delusional beliefs of an already existing relationship with an idealized victim. Erotomanic stalkers include about 5% of all stalkers. A large sample collected across multiple jurisdictions in the United States and Canada suggested 62% were simple obsessional, 35% were love obsessional, and 3% were erotomanic (Mohandie, Meloy, McGowan, & Williams, 2006).

After more attention began to be placed on stalking and it became clear that the majority of stalkers had a significant intimate relationship with their victims (Sfiligoj, 2003), the natural association between stalking and domestic violence was explored. Douglas and Dutton (2001) argue that most stalkers are similar to the borderline/dysphoric batterers identified by Holtzworth-Munroe and Stuart (1994). They share the extreme emotional dysregulation in terms of depression, anger, jealousy, and



Kevork Djansezia/©AP/Wide World Photos

Figure 10.2. One of the first widely publicized cases of celebrity stalking involved Robert Bardo, who stalked and murdered the young actress Rebecca Schaeffer.

substance abuse and are further likely to have suffered childhood trauma and poor emotional attachment to their caregivers. Research also reveals that the severity of domestic violence experienced in an intimate relationship is related to future stalking (Logan, Leukefeld, & Walker, 2000) and that more severe stalking behaviors are related to higher levels of domestic violence and more extreme psychopathology (Norris, Huss, & Palarea, 2011).

Stalking generally comprises a variety of different behaviors that can include minor behaviors such as following the victim, leaving unwanted phone calls, and sending unwanted gifts to more serious behaviors such as making threats or damaging property (Langhinrichsen-Rohling, Palarea, Cohen, & Rohling, 2000). However, the most prevalent stalking activities appear to consist of following, spying, or standing outside the victim's home (77%), unwanted phone calls (52%), overt threats (52%), sending unwanted letters or items (30%), vandalization of property (29.5%), and killing or threatening pets (7.5%). Not unlike some of the research on domestic violence perpetration in general, the overwhelming majority of victims tend to be women (78%) and the overwhelming number of perpetrators are men (87%). In addition, women are more likely to have a prior relationship with their stalker and overall about 25% to 40% of stalkers physically

assault their victims. Some of the risk markers for stalking include extreme jealousy and possessiveness, need for control, absence of friends of one's own, and poor social skills (Tjaden & Thoeness, 1998). In a subsample of the original Mohandie study, Eke, Hilton, Meloy, Mohandie, and Williams (2011) found stalking recidivism rates of 56% and that it was accurately predicted by the severity of previous criminal history and a prior diagnosis of a mental illness. Rosenfeld (2004) identified the existence of prior threats and previous relationship were some of the strongest predictors. Unfortunately, there is little research on treatment specifically for stalking offenders (Rosenfeld, Fava, & Galietta, 2009).

Reflection and Review

1. How should the prevalence of domestic violence be critically understood?
2. Why is the Conflicts Tactics Scale controversial?
3. How is risk assessment within a domestic violence context similar to and different from our previous descriptions of the risk assessment process?
4. What is the difference between battering and domestic violence?
5. Why is the discussion of gender controversial in domestic violence?
6. How is stalking related to domestic violence?

Key Terms

battering	intergenerational transmission of violence
clinical sample	mandatory arrests
community sample	protective order
femicide	restraining order

Further Readings

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11 Juvenile Delinquency and Juvenile Justice

Chapter Objectives

1. Describe the historical role of the juvenile court
2. Explain the typical process for a juvenile upon entering the juvenile court system
3. Identify the different risk factors for juvenile violence
4. Know the different ways forensic psychologists get involved in the juvenile court system
5. Describe the nature of school shootings

Greater media attention to crimes involving children, especially school shootings and other violent crimes, has increased the attention placed upon the juvenile justice system and juvenile delinquency (Krisberg & Wolf, 2005). Historically, childhood has been a distinctive period in human development during which future adults are shaped and life-altering lessons are learned. The view of a distinctive period between childhood and adulthood, adolescence, is a more recent development. Adolescents are considered more advanced than children and able to accept some of the responsibility that occurs in adulthood like driving a car or holding a job. Regardless, they are not adults and are not afforded all the rights of adults. Adolescents are typically the focus of juvenile interventions. This focus occurs not only because they often commit delinquent behaviors and serious violent behaviors but also because most jurisdictions specifically bar children, completely before age 7, from culpability for any delinquent or criminal behavior. Although the word *juvenile* refers to any child under the age of majority, most of the research and resources of the juvenile system focuses on adolescents.

Special detention centers were established in many places in Europe before the nineteenth century, and juvenile courts were first established at the turn of the twentieth

century in the United States. They were built squarely on the notion that children were different than adults. Policymakers believed that if adolescents committed societal transgressions, they should not be punished as adults but instead rehabilitated because there was still time to prevent them from leading antisocial lives as adults. However, society has become increasingly concerned about the perceived increase in the frequency and severity of crime committed by children and adolescents. Some of this perception has been fueled by sensationalized crimes committed by juveniles such as the death of a young girl while her playmate was reportedly practicing professional wrestling moves. Many of the public perceptions that juvenile violence has been increasing dramatically are fueled by public awareness of high-profile crimes such as the death of Tiffany Eunick in 1999. Kathleen Grossett-Tate was watching 6-year-old Tiffany, the child of a friend, one evening along with her 12-year-old son, Lionel Tate. Toward the end of the evening Ms. Tate went upstairs to rest. Lionel later came to wake her up reporting that Tiffany had stopped breathing. After Tiffany's death, Lionel was charged with her murder. The case made national headlines in the United States after Lionel and his attorneys claimed that Tiffany had died as a result of the 170-lb Lionel practicing professional wrestling moves on the 45-lb Tiffany. Prosecution experts testified that her injuries were brutal and could not have occurred as Lionel claimed. After Lionel's mother turned down a plea bargain that would have resulted in him serving a 3-year sentence, Lionel was convicted and became the youngest person in the United States to be sentenced to death even though the sentence was later overturned.

Even prior to the advent of this view, the courts were beginning to think that juvenile courts should be more similar to adult criminal courts and protect juveniles by affording them the same rights that adults received in the adversarial criminal courts. Changing views of the courts and the general public led to some gray areas in dealing with juveniles. Could they be rehabilitated and should that be the goal of the juvenile courts, given some of the serious crimes being committed by juveniles? At what age are juveniles as responsible for their crimes as adults? How could any of these answers be determined?

As a result, the juvenile justice system has received a great deal of attention and undergone some significant changes in the latter part of the twentieth century and the early part of the twenty-first century. The role of the forensic psychologist has changed greatly in a context in which some questioned whether the role of mental health professionals was already too expansive (Melton et al., 2007). Some of the duties we have talked about in terms of adults such as competency and insanity were unheard of in juvenile court but now have become more common. In addition, changes in the law intended to give juveniles the **due process** protections common in adult criminal matters also may have discouraged the rehabilitation model previously common in juvenile courts. This change occurred while public perception, which has not always matched reality, has been that juvenile crime and specifically juvenile violence is increasing. Therefore, the public belief has been that there is greater need to punish juveniles instead of rehabilitate them. This chapter will examine delinquent or antisocial behavior committed by juveniles in the context of the evolving juvenile court and the overall changes that have made it more likely for juveniles to be tried as adults. We will also pay specific attention to contemporary issues such as school violence and school shootings.

History of the Juvenile Court

The first juvenile court was established in 1899; since then, juvenile courts have spread to almost every industrialized country in the world (Zimring, 2000a). Immediately, the juvenile courts were distinguished from their adult counterparts. The focus of the juvenile justice system was on the rehabilitation of juveniles, not on their conviction and punishment. Juveniles were viewed as not fully responsible for their acts and in need of assistance to avoid a continued life of adult criminal behavior. The focus on rehabilitation instead of punishment meant that the court did not concentrate on the offense but on the offender. Practically, this meant a juvenile was not automatically punished more harshly for a severe transgression than for a minor one. If a juvenile committed a minor crime but was in need of a number of different services that the juvenile court could offer such as academic assistance, adult supervision, or mental health treatment, she would receive it. A juvenile who stole the hubcaps off a neighbor's car was more likely to compensate the neighbor for the hubcaps by working for the money than be incarcerated because she had broken the law. It was believed that such a practice would teach the juvenile a lesson and that incarceration was not the most effective or cost-efficient way to prevent recidivism.

Juvenile proceedings were not adversarial, because the child was not only being punished but being cared for by a judge who had broad discretion in rendering decisions (Steffen & Ackerman, 1999). This approach was based on the legal notion of parens patriae (see Chapter 7). The juvenile courts believed they had a responsibility to protect and take care of juvenile offenders and therefore took additional steps like closing the proceedings to outsiders and sealing juvenile records. Many of the offenses that brought juveniles before the juvenile courts were status offenses. **Status offenses** are offenses that could only be committed by someone who was not yet an adult, such as truancy and running away from home. They are viewed not as crimes, but as juvenile offenses. Generally, juveniles were perceived as lacking culpability for their offenses. Any child under age 7 clearly was not responsible and it was frequently believed that children from 7 to 14 were not able to form criminal intent (Otto & Borum, 2003).

From the early intent of the juvenile system, it is easy to see the implications for the relevance of the law. The juvenile courts were established to be different from the traditional punitive approach taken in the adult criminal courts; they were established to be therapeutic. The juvenile court intended to be rehabilitative by focusing on the needs of the children and the personal and environmental factors leading to their delinquent behavior. By doing so, they believed that children would be less likely to commit additional crimes, less likely to exhibit problematic behavior, and more likely to become productive members of society. However, many questioned whether the courts fell short of their intended rehabilitative goals and whether it was appropriate to treat juveniles differently, especially at the cost of many of the constitutional rights adults were afforded.

The juvenile courts in the United States began to change in the 1960s. In *Kent v. United States* (1966), the Supreme Court argued that juveniles received the worst of the juvenile system and the adult system. They were given neither the due process safeguards

Box 11.1. Altering the Juvenile Justice System: *In re Gault*

In re Gault (1967) has been considered one of the most important, if not the most important, cases in the history of juvenile law. Despite its unique impact on the juvenile justice system, *In re Gault* involved a fairly common set of circumstances. Gerald Gault was a 15-year-old boy who was on probation for accompanying another boy who had stolen a wallet. In June 1964, he was taken into custody by local law enforcement officers with his friend, Ronald Lewis. A neighbor had complained to police that Gault and his friend were making obscene and lewd phone calls to her residence. When Gault was arrested, his parents were not home and the officers did not leave any notice at the home that Gault had been taken into custody. Gault's parents only learned of his arrest after his mother arrived home early that evening and sent their older son to check on Gault's whereabouts.

After eventually contacting the appropriate authority, his mother was told a hearing would take place on the following day. At the hearing there were no witnesses sworn in, including the complaining witness, and Gault was not given an attorney nor were any of his rights explained. Eventually, Gault was committed to a state school until he was 21 years old. On appeal, it was argued that the procedures used to commit him to the facility were unconstitutional and violated several of his due process rights. The United States Supreme Court agreed and held that juveniles should be given due process rights as adults, receive written notice of any court proceedings, be advised of their right to counsel, be advised of their right against self-incrimination, and given the right of sworn testimony of their accusers and to cross-examine them.

of adults or the benefits of treatment that children were suppose to receive. *Kent* formally recognized the right of juveniles to have the assistance of counsel if they faced criminal charges. Another case, *In re Gault* (1967), indicated the Court's skepticism of the juvenile system more explicitly (Box 11.1). The Supreme Court clearly stated that juveniles were persons to be protected under the Bill of Rights and that they should be given due process (*In re Gault*, 1967). Though these cases required that juveniles receive some of the due process rights long considered essential to adult criminal defendants, they also began to suggest that the divide between adults and children was not as wide as had been previously thought.

Beginning in the 1980s and 1990s, almost every state in the United States changed their juvenile statutes to reduce the emphasis on rehabilitation (Zimring, 1998) and create more of a balance between rehabilitation and punishment. These changes were due in part to the public perception that juvenile crime was dramatically increasing. The de-emphasis of rehabilitation was marked by several procedural trends. The upper age range was frequently lowered for jurisdiction over a juvenile. For example, previously a juvenile court may have responsibility for supervision of a child until he or she turned 21 years of age but many states reduced that age from 21 to 16. Certain serious offenses automatically became the responsibility of the criminal courts. Age ranges for transfer to criminal court were expanded downward so that when previously only children as young as 16 could be subject to criminal courts, children as young as 14 or

Table 11.1. Differences in the U.S. Juvenile and Adult Systems

	Juvenile system	Adult system
Detention	Taken into custody	Arrested
Culpability	Found or adjudicated delinquent	Found guilty
Disposition	Committed or placed	Incarcerated
Presence of jury	No right to a jury trial	Right to a jury trial
Treatment	Right to treatment	No right to treatment
Proceedings	Informal	Formal
Status offenses	Recognized	Not recognized
Death penalty	Does not apply	Applicable in capital offenses
Official record	Sealed	Permanent

Source: Adapted from Shoemaker & Wolfe (2005)

12 may be transferred from juvenile court to adult criminal court. Juvenile commitments also were extended into adult criminal sentences instead of expiring when the juvenile reached a particular maximum age. However, there still remain important differences in terminology and practice between the juvenile and adult systems of justice (Table 11.1) (Shoemaker & Wolfe, 2005).

Processing in the Juvenile Courts

Although there are variations across different jurisdictions, the processing of juveniles through the juvenile court systems shares a number of similarities across the United Kingdom, Canada, and the United States (Hoge & Andrews, 1996). The process normally begins with some sort of law enforcement contact. The contact may be the result of a complaint by a parent, a school, or a member of the public and can lead to a variety of legal outcomes, even at this stage. Law enforcement can choose to question, release, release with a warning, take into custody, or detain for an extended period of time (see Figure 11.1). Normally, it is frowned upon to hold a child with adult offenders, but in some jurisdictions there may not be separate juvenile facilities and in these instances there are often legal requirements that prohibit extensive incarceration near adult offenders. If a juvenile is formally charged or brought into custody, some form of intake normally follows. Juvenile intakes are usually performed by officers from the juvenile probation office or prosecutors. They consist of an examination of the specifics of the alleged offense and whether there is sufficient evidence to move forward with the allegation or dismiss the case. There is considerable variation across different jurisdictions regarding the specifics of this process. If the determination is made to go forward after the initial intake, the adjudication process continues. Juveniles may be detained prior to their case being formally adjudicated, held over for a juvenile hearing to determine their guilt or innocence, transferred to criminal court, or again the charges

Carlos Barria/Reuters/NewsCom

Figure 11.1. A juvenile is taken into custody by police officers for trespassing in Pinellas Park, Florida, March 23, 2005.

could be dismissed at this stage. If the juvenile continues in the juvenile court, a hearing is normally scheduled to determine the outcome or disposition of the case (Hoge & Andrews, 1996).

Prior to the disposition of the case, the probation officer or court official normally prepares a formal report to assist the court. If the court determines the juvenile is delinquent, this report serves as the basis for formulating any intervention plan for the juvenile. For example, the probation officer may have detected through his investigation that the juvenile is often unsupervised and routinely truant from school. Part of the plan could be to mandate that the child attend school regularly or face additional penalties and require the juvenile to participate in an after-school activity. If the juvenile is found to be delinquent, the judge identifies appropriate interventions and may order additional evaluations to better inform the court about a possible disposition of the case. For example, the initial report from the probation officer may have suggested some possible mental health needs. The judge may require the juvenile to undergo a psychological evaluation to further examine the necessity of psychotherapy or psychiatric treatment. Once the judge has determined the final steps necessary, the juvenile must follow the judge's orders. These orders may consist of restitution to the victim, obtaining a job, attending therapy, reporting to the probation officer, abstention from drugs and alcohol with regular drug testing, or incarceration in a juvenile detention center.

The length and conditions of the probation may be determined at this time or more likely left open-ended and dependent on the juvenile meeting all of the conditions of the probation (Roberts, 2004). Typically, once juveniles have met all the conditions of their probation, they are released from the authority of the juvenile court unless there are additional concerns or new charges are filed. This description only provides a broad outline and specific jurisdictions may slightly alter this process or even depart significantly from it. However, in most instances, these steps are characteristic of the process involved in moving a juvenile through the juvenile court system.

Juvenile Delinquency and Juvenile Offenses

What exactly is meant by the term **juvenile delinquency**? Juvenile delinquency is frequently used to describe behavior that is a violation of criminal law but that is committed by individuals who have not yet become adults. The nature of juvenile offenses is varied and can include anything from status offenses to murder. Moreover, the public's view of these crimes often contrasts with the realities. The Department of Justice is a common source for crime statistics in the United States and has reported that juvenile crime was at its lowest in 20 years at the turn of the century (U.S. Department of Justice, 2001). Even at its highest point, less than 6% of youths under 18 years of age have ever been arrested and less than 10% of juveniles who have committed crimes have committed violent crimes (Snyder, 2000). More recent reports suggest that these trends have continued and that the number of juvenile cases handled by juvenile courts has decreased across all major crimes in the last 10 years (Puzzanchera, Adams, & Hockenberry, 2012). Nonetheless, the public generally believes there has been a significant increase in juvenile crime. This belief may be partially a result of the increase in news coverage on juvenile crime, despite the decreased prevalence (Dorfman & Schiraldi, 2001). It seems as if stories about the next Columbine are a frequent part of the news.

Despite the good news that there seems to be an overall trend for a decrease in the juvenile crime rate, there are some problems and distressing trends. Overall, there are about 2 million juvenile arrests each year: 1 million are sent to juvenile court, about 500,000 are admitted to detention centers, and about 10,000 of these juveniles are sent to criminal court for further adjudication (Shoemaker & Wolfe, 2005). About 61% of juvenile proceedings are delinquency proceedings, 19% for status offenses, and 19% for victimization or abuse of children (Ostrom, Kauder, & LaFountain, 2001). Research indicates that a distressing number of juvenile offenders are younger and that more juvenile cases are being sent to adult courts (Sickmund, 1994). Specifically, 58% of all juveniles are younger than 16 years of age, 32% are younger than 15 years old, and 9% are 12 and younger (Snyder & Sickmund, 1999; U.S. Department of Justice, 2001). These figures are especially problematic because the younger a juvenile offender is, the more likely he is to commit more violent and more serious offenses than juveniles who initially offend at a later age (Cottle, Lee, & Heilbrun, 2001). Furthermore, a dramatic increase in juvenile crime has occurred among girls. Overall, there has been an 86% increase in female juvenile crime and upward trends have continued in the last

few years with girls now accounting for 28% of juvenile caseloads compared to 19% in 1985 (Puzzanchera et al., 2012). The rise in juvenile crimes among females is at least partially the result of runaways who turn to shoplifting, prostitution, and drug offenses to cope with living on the streets (Henriques & Manatu-Rupert, 2001).

One type of juvenile offense not typically seen as a serious offense but often identified as a gateway for serious offenses are status offenses. Curfew and loitering violations more than doubled from 1993 to 1997, but then declined 17% by 1999 (Snyder, 2000) and 25% by 2009 (Puzzanchera et al., 2012). Although these crimes are less serious, there are few opportunities for rehabilitation because of the increased focus on more serious offenders and punitive interventions for less antisocial juveniles. Placement of juvenile status offenders then becomes problematic because the juvenile court does not want to encourage continued antisocial behavior by placing them in situations where they may be exposed to negative peer influences. If the court places a young juvenile who has committed a relatively minor offense in a juvenile detention center, there is a risk that he will begin to associate with individuals who are more antisocial and adopt their antisocial behavior.

Another significant area of juvenile delinquency is the commission of property crime. Property crimes typically include offenses like burglary, theft, and arson. About one-third of all juvenile arrests are for a property-related crime (Godwin & Helms, 2002). Burglary is often characterized by entering a structure of some kind and unlawfully stealing property on those premises. Theft is defined as the unlawful taking or possession of property and differs from burglary in that the former entails an offender stealing while in or around a property legally. Theft would generally include crimes such as shoplifting, pickpocketing, or purse snatching. Finally, arson is often considered a property crime but also can be considered a violent crime because of the potential harm to other persons. Arson is the burning of property and may be committed for monetary gain or for the sheer enjoyment of the act. Property crimes have been decreasing over the last 30 years (Puzzanchera et al., 2012).

Risk Factors for Juvenile Delinquency

A substantial research base now exists that better identifies some of the causal pathways for juvenile delinquency (Moffitt, 1993, 2006). Typically, the risk factors for juvenile delinquency are derived from several major areas and reflect the developmental nature of juvenile delinquency compared to adult antisocial behavior. The individual, the family, school, peers, and the neighborhood all contain risk factors relevant to juvenile delinquency (Redding, Goldstein, & Heilbrun, 2005). Substance abuse, mental health concerns, general impulsivity, and difficulties in problem solving are important individual risk factors. Many argue that many of the problems with juvenile delinquency arise from the family context. For example, poor parental attachment, a lack of parental supervision, and harsh or generally ineffective discipline are the most significant familial risk factors. School is also a significant area of concern for juvenile delinquency. Academic difficulty, unrecognized learning disabilities, poor school attendance, and general academic dissatisfaction are all risk factors for juvenile delinquency. Delinquent peers

and gang membership are also potential concerns related to juvenile delinquency. Exposure to violence, drug dealing, and access to firearms are neighborhood risk factors (Redding et al., 2005).

Cottle et al. (2001) conducted a meta-analysis examining the most significant risk factors related to general recidivism among juveniles. They organized 30 different possible factors into eight categories: demographic information, offense history, family and social factors, educational factors, intellectual and achievement factors, substance use history, clinical factors, and formal risk assessment. Cottle et al. (2001) found that demographic factors such as being male, of a minority race, and from a low socioeconomic level were all associated with juvenile recidivism. Race was not a significant predictor once socioeconomic status was controlled for in the analysis. This finding is typical across recidivism studies no matter the form of crime or violence predicted. Although race is often associated with higher risk for reoffending, it appears that general finding is related to the lower socioeconomic status of minority individuals in the United States and not to their racial identity. Offense history variables were the biggest predictors of recidivism including factors such as a younger age at first legal contact, younger age of first juvenile commitment, number of prior arrests, number of prior commitments, commitment of more serious crimes, and a longer first incarceration. Although offender history, family, and social factors were the most consistent categories of predictors, there also were a number of dynamic predictors that were related to general recidivism. Factors like family instability, association with delinquent peers, poor use of leisure time, conduct problems, nonsevere pathologies, poor achievement scores on standardized tests, and substance use were all predictive of recidivism and also can be directly targeted for intervention. At least one study has suggested that it may be more appropriate to use different risk factors for different types of juvenile offenders though (Mulder, Vermunt, Brand, Bullens, & Van Marle, 2012).

However, there are also a number of protective factors that are related to a reduction in risk for juvenile delinquency (DeMatteo & Marczyk, 2005). Protective factors are especially important to juveniles because of the increasing demand for **strength-based assessments** across the mental health system but especially in regard to juveniles, given the rehabilitative history of the juvenile courts. Protective factors function the same way they did in Chapter 5. In this instance, protective factors reduce the risk of a juvenile getting into additional trouble or committing delinquent acts. Some define protective factors as the absence of a particular risk factor, while others distinguish them as separate mechanisms that reduce the likelihood of negative event. The research has found that the more protective factors a juvenile exhibits, the greater the likelihood that he or she will not recidivate (Werner, 2000). Protective factors reduce risk by interacting with the risk factors and moderating their effect or by reducing risk independently (Clayton et al., 1995; Hoge, Andrews, & Leschied, 1996).

Though the research identifying protective factors is not as abundant as that for risk factors, there has been some research examining the role and impact of protective factors. Generally, intelligence (Hoge & Andrews, 1996), negative attitudes toward delinquent behavior (U.S. Department of Health and Human Services [DHHS], 2001), and other personality/psychological variables such as sociability and a positive temperament

have been protective factors for delinquent behavior (DeMatteo & Marczyk, 2005). A positive family influence and a close relationship with a family member also have been found to be protective factors (Farrington & Ttofi, 2012). One of the better sources of protective factors may be the school environment. In general, educational achievement, commitment to school, and participation in school-related activities have been cited as protective factors by some researchers (e.g., DeMatteo & Marczyk, 2005). Even staying in school serves as a protective factor (Henry, Caspi, Moffitt, Harrington, & Silva, 1999). One factor that has had mixed success is the presence of prosocial peers. Although delinquent peers have been consistently associated with delinquent behavior, the evidence has not been as clear if a juvenile actually has positive peers surrounding him (DHHS, 2001). Nonetheless, there are clearly some factors that reduce the likelihood of delinquent behavior, many of which may be dynamic and amenable to the interventions we will discuss later in this chapter.

Juvenile Violence

An aspect of juvenile crime and delinquency that appears to be of significant concern for the general public is juvenile violence. In general, the violent crime rate in the United States is higher than it was 50 years ago, higher than in most industrialized countries, and violence has grown worldwide (Garbarino, 1999; Rutter, Giller, & Hagell, 1998). Furthermore, homicide is the leading cause of death among Hispanic and African American adolescent males (Hoffman & Summers, 2001). However, crime rates for violent crimes such as murder, sexual assault, and aggravated assault are at their lowest in almost 30 years for juvenile offenders, except for female juvenile offenders. The rate has risen 74% since 1980 for female offenders (Snyder, 2000).

Risk Factors for Nonsexual Violence

In general, there is significant overlap between the risk factors associated with general antisocial behavior and violent behavior among juveniles. This finding is partially the result of the criminal diversity of violent juvenile offenders. Juveniles who perpetrate violence tend to commit a variety of crimes and do so frequently (Farrington & Loeber, 2000). In fact, it has long been recognized that violent juveniles commit more nonviolent crimes than they do violent crimes (Hamparian, Schuster, Dinitz, & Conrad, 1978). Individual risk factors for the commission of nonsexual violence include impulsiveness, hyperactivity, poor behavioral control in general, greater risk taking behavior, attentional problems, reduced intelligence, and poor educational performance (Farrington & Loeber, 2000). As with general delinquent behavior, there are a number of family-related risk factors for juvenile violence. Having a parent who has been convicted of a criminal offense; parental rearing practices that include low attachment, harsh discipline, and poor supervision; child abuse; low socioeconomic status; and family conflict are all risk factors for juvenile violence with parental criminal behavior, inappropriate parenting practices, and low socioeconomic status as the strongest predictors (Lipsey & Derzon, 1998). It is

very clear that associating with delinquent or antisocial peers also is a risk factor for juvenile violence and furthermore that the spread of gangs in the United States has played a significant role in the spread of juvenile violence. The presence of gangs is also related to a number of neighborhood risk factors for juvenile violence such as living in an urban area and the availability of drugs and guns (Farrington & Loeber, 2000).

In one study, Clingempeel and Henggeler (2003) divided violent juvenile offenders into persistors and desistors. **Persistors** are juvenile offenders that continue committing violent behaviors and **desistors** discontinue their violent behavior before they emerge from adolescence. Using these two designations, Clingempeel and Henggeler (2003) found significant distinctions between the types of violent offenders who are likely to continue their violent behavior and those who are not. In general, violent juveniles who stopped their violent behavior, desistors, engaged in fewer violent behaviors during adolescence, committed fewer property crimes, were less aggressive and more positive toward peers, reported experiencing greater emotional support from others, exhibited higher job satisfaction, identified closer relationships with peers, and reported fewer psychological difficulties. These differences appear not only in juveniles who act violently and those who do not but also between those who continue to be violent and those juveniles who discontinue the violence.

Although there is a significant amount of literature identifying risk factors for nonsexual violence, the literature examining risk factors related to nonsexual violent recidivism is sparse. Distinguishing those factors that lead to violence and those that lead to repeat violence is important in assessing risk. Forensic psychologists do not normally assess risk in an individual without any prior history. They typically are sought out after violence has already occurred and the courts need some determination of the probability of future violence for placement purposes. The literature on recidivism for nonsexual violence is so sparse that Heilbrun, Lee, and Cottle (2005) were able to identify only four published studies, and only one of which used violence as the outcome variable. The remaining studies used any reoffense as the outcome variable. As a result, there is little that can be gleaned from the research.

There has been some examination of the influence of protective factors in regard to juvenile violence. Stouthamer-Loeber, Loeber, Farrington, and Zhang (1993) failed to find any protective factors that were not extreme versions of risk factors for violence. This finding underscores the unresolved issue as to whether something should only be considered a protective factor if it is distinct from the identified risk factors or if protective factors can simply be an absence of the identified risk factors. However, there are additional factors that have been identified as distinguishing nonviolent youth from violent youth. Good school performance, appropriate parental supervision, secure attachment, and association with prosocial peers have shown some reduction in delinquency (Rapp & Wodarski, 1997).

Risk Factors for Sexual Violence

About 19% of forcible rapes are committed by male perpetrators under the age of 19 (U.S. Department of Justice, 1999) and about one-third of child molesters are juveniles

(Finkelhor, Ormrod, & Chaffin, 2009). Thus, the system has recognized that juveniles account for a significant percentage of sexual crimes. In 1982, there were only 20 programs specifically targeting juvenile sex offenders (National Adolescent Perpetrator Network, 1993), but 20 years later this number had grown to well over 1,300 (McGrath, Cumming, & Burchard, 2003). Overall, the rate of sexual reoffending appears to vary between 2% and 14% for juveniles, but this figure depends on the sample and the length of follow-up period (Waite et al., 2005). In a study examining two different samples of juvenile sex offenders, one group of sex offenders in a specialized intensive treatment program for sex offenders and sexual offenders from a less intense program of general offenders were compared 10 years after release. Both groups were more likely to be rearrested for a nonsexual offense (31% for the specialized treatment group and 47% for those from the general offender population) than a sexual offense (less than 5%). Furthermore, those offenders from the specialized sexual offender treatment program took longer to reoffend for all offense types compared to the group of juvenile sexual offenders from the general offender program. Waite et al. (2005) also found that impulsive/antisocial behaviors were significantly related to reoffending.

Heilbrun et al. (2005) conducted a preliminary study on the available studies examining juvenile sex offenders and the risk factors related to reoffending. They discovered four significant risk factors for reoffending among juvenile sex offenders. Being an acquaintance of the victim was the most significant predictor of reoffense, followed by not receiving any form of treatment, a less severe initial offense, and being a younger offender. Juvenile sex offenders who victimized acquaintances rather than strangers or friends were more likely to reoffend. Juveniles who had received treatment were less likely to reoffend. One potentially counterintuitive result was that juvenile sex offenders who committed less severe initial offenses were more likely to reoffend, possibly suggesting a tendency to escalate in the severity of their offense history. The younger the offender, the more likely he or she also was to reoffend. One question remains though, do these offenders really differ from counterparts who perpetrate nonsexual violence (Box 11.2)?

As with adult offenders, most research has examined male sexual offenders, but there is growing awareness that girls also perpetrate sexual offenses. Currently, our best estimates are that about 7% of juvenile sexual offenses are committed by girls (U.S. Department of Justice, 2002; Finkelhor et al., 2009). One study that focused on juvenile sex offenders compared 122 male and 61 female juvenile sex offenders (Vandiver & Teske, 2006). Female offenders were younger at the time of arrest, had younger victims, were likely to receive shorter sentences compared to the male offenders, and were perpetrated on girls and boys proportionately. Male juvenile sex offenders were more likely to victimize girls. These early results may suggest that female juvenile sex offenders are not identical to their male counterparts and may have different risk factors for initially offending or reoffending. However, this claim is yet to be thoroughly examined.

So far, there has been a lot of discussion about risk factors whether they are for delinquency, general violence, or sexual violence. The reason for discussing and listing all of these different risk factors is not necessarily so you have a comprehensive list of the risk factors relevant to juveniles. By examining these risk factors, some of the

Box 11.2. Focus on Research: What Is So Special About Male Adolescent Sexual Offending?

Causal theories about juvenile sexual offending have primarily focused on things unique to sexual offending and only a minority of scholars have suggested that sexual violence is part of a generally antisocial response. Seto and Lalumière (2010) decided to ask the question about whether there was anything unique to the sexual offending of adolescent males compared generally to violence of adolescent males. They conducted a meta-analysis using 59 independent studies and over 16,000 adolescent offenders. Their results generally supported the idea that adolescent male sex offenders are indeed unique and not a result of generally antisocial patterns. They found that adolescent sex offenders had less extensive criminal histories, fewer antisocial peers, and fewer substance abuse problems compared with nonsexual offenders. Furthermore, explanations focusing on sexual abuse, exposure to sexual violence, early exposure to sex, or pornography were supported, while general explanations were not.

Many people believe meta-analyses are superior to single studies because they statistically combine the literature. Unfortunately, that notion is false. Meta-analyses suffer from methodological limitations, as any single study can. For example, the very selection of the studies to include or exclude can alter the results of a meta-analysis. Should only published or unpublished studies be included? Including only published studies leads to the so-called file drawer problem where studies with significant findings are overrepresented in the meta-analysis. Seto and Lalumière (2010) pointed out more specific limitations with their study. For example, sex offenders may be more likely to be included in their meta-analysis because sex offenders are more likely to be institutionalized than nonsexual offenders and thereby those nonsexual offenders who are often studied in these single studies represent a more pathological or severe group. Seto and Lalumière (2010) also reported that they did not have enough studies to sufficiently study the relationship of some factors such as sexual victim age to the variables of interest. As a result, forensic psychologists should continue to critically evaluate findings from meta-analyses as they would other studies of interest.

differences between the factors that are important to adults versus those that are important to juveniles are highlighted. In general, the juvenile risk factors tend to be much more diverse and more likely to respond to directed interventions. These types of differences are important as we begin to discuss the role of forensic psychologists in the system.

Role of the Forensic Psychologist in Juvenile Courts

As a result of many of the changes that have taken place in the juvenile court system, forensic juvenile practice has significantly increased (Grisso, 2003c), even though psychologists had been involved with the juvenile courts almost from their inception (Otto & Borum, 2003). Psychologists were originally part of the rehabilitation process because

there was a need for treatment and a need to identify whether a particular juvenile was amenable to treatment and the precise circumstances under which he would benefit from certain rehabilitation efforts. Today, there are a wide variety of roles for the forensic psychologist in the juvenile court system, including treatment, evaluation of treatment amenability, transfer evaluations, competency evaluations, insanity or mental status evaluations, and violence risk or threat assessments. There also are a variety of different types of offenders outside of status offenders, such as violent offenders, sex offenders, and younger offenders, that have complicated these roles.

Evaluating Treatment Amenability

Despite the dramatic changes in the juvenile court, amenability to treatment continues to be the most prominent role of forensic psychologists within the juvenile court system (Melton et al., 2007). The continued prominence of this role is a reflection of the importance of rehabilitation for juveniles even though it is not the sole focus of the juvenile courts. Amenability to treatment refers to the need and responsiveness of the juvenile to treatment and is separate from issues such as the severity of the current crime. For example, a forensic psychologist may attempt to identify any treatment needs of a juvenile, such as a need for substance abuse treatment, and whether the juvenile appears willing and able to benefit from treatment. A juvenile would need to exhibit sufficient intelligence and motivation for any treatment to be meaningful and the evaluation attempts to address these issues. Amenability evaluations normally identify the factors likely to lead to effective interventions, the interventions most likely to be successful, and any factors likely to reduce the effectiveness of those interventions (Grisso, 2003c). In instances where there are clear treatment needs, the forensic psychologist can play a very important role in the juvenile process (Hoge & Andrews, 1996). A forensic psychologist is often asked to perform an evaluation of a juvenile to assist in making initial procedural or dispositional decisions, whether that be declaring the juvenile a delinquent or transferring him or her to criminal court (Steffen & Ackerman, 1999). Sometimes attorneys use the treatment amenability evaluation as a bargaining tool to encourage treatment as an alternative to incarceration or transfer to criminal court.

Providing Treatment

Given the focus on treatment both in decisions regarding amenability to treat and specifically in transfer decisions, it is important to assess the effectiveness of treatment when forensic psychologists are asked to provide it. Similar to general treatment discussed in Chapter 2, many have questioned the effectiveness of treatment with juvenile offenders. Although treatment effectiveness of juvenile delinquency is among some of the poorest outcomes in all of psychology (see Babcock, Green, & Robie, 2004), research has consistently identified that effective interventions can be designed for juveniles with a history of antisocial behavior or delinquency. Moreover, the increasing rate at which juveniles are being diagnosed with

mental health issues makes treatment even more imperative. Before the 1980s, research examining the effectiveness of juvenile treatment was discouraging (Lipsey, 1992). However, since that time, treatment has advanced and more recent reviews suggest a much more favorable outcome for the treatment of juveniles (Lipsey & Wilson, 1998; Lipsey, 2009).

Lipsey and Wilson (1998) conducted a meta-analysis of 200 different studies examining the effectiveness of different juvenile interventions. They concluded that intervention programs for serious juvenile offenders can reduce reoffending rates. For example, they found that the best programs could reduce reoffense rates by 40% (Lipsey & Wilson, 1998). Nonetheless, not all interventions are equally effective. Interventions that take a single approach are not as effective as interventions that are multimodal and focus on developmentally appropriate skills. Interventions designed to scare or punish juvenile offenders into not committing antisocial behaviors have generally had negative effects (Henggeler & Schoenwald, 1994; Tarolla, Wagner, Rabinowitz, & Tubman, 2002). For example, boot camps became popular in the 1990s, with millions of dollars set aside for their establishment (McNeece & Jackson, 2004). These camps required juveniles to lead a regimented military existence including the early wake-up for drills, continual exercise, harsh discipline, rigid dress codes, and routine inspections to make sure they are following camp policies. However, research suggests that results have been tremendously disappointing and that there are less costly alternatives (Tyler, Darville, & Stalnaker, 2001).

New and effective treatments for juveniles have been developed. For example, Multisystemic Therapy (MST) is one of the best validated treatment approaches for juveniles and has been found to reduce long-term antisocial behavior, fit the varied needs of juveniles, and be comprehensive (Henggeler et al., 1999). MST is based on numerous principles that focus on the match between the specific problem and the wider system, the strengths and weaknesses of the systems that surround the juvenile, changing current behavior and relationships, collaboration with the family, matching the developmental requirements of the juvenile, ongoing evaluation of the intervention, and promotion of long-term effects and generalization across different systems (Johnson & Helms, 2002). By focusing on the multiple systems (peers, family, school, society) that the juvenile has contact with, it is expected that the more systematic approach will address the numerous entry points that can influence the development and potential antisocial acting out the juvenile has previously displayed.

Research is increasingly supporting the use of MST for juvenile offenders. Timmons-Mitchell, Bender, Kishna, and Mitchell (2006) conducted the first randomized clinical trial of MST that was not overseen by the treatment developers. Ninety-three juveniles were either assigned to MST or treatment as usual. The treatment as usual condition consisted of probation officers referring juveniles to a variety of different interventions such as alcohol and drug abuse, anger management, and individual and family counseling. The two different approaches were evaluated 6-months and 18-months after treatment. Results generally found a reduction in rearrests and improvement in several functional areas for juveniles (school work, behavior at home, behavior in the community, and moods and emotions) in the MST condition compared to the treatment as usual. Treatment approaches such as MST hold the most promise for forensic

psychologists providing treatment directly to juveniles involved in the juvenile court system. However, Littell (2005) has identified some significant problems with MST that call into question its effectiveness.

Lipsey (2009) conducted a meta-analysis specifically focused on the factors that characterize effective interventions for juveniles instead of the types of programs themselves. He found that in general intervention philosophy, serving high-risk offenders, and quality of implementation were all related to intervention effectiveness and that there were relatively few differences across different types of programs when these variables were controlled for in the study.

Transfer Evaluations

Although the issue of transfer (or waiver in some jurisdictions) to criminal court can be one aspect of the decision regarding amenability to treatment, it also can be a separate issue for juveniles. Transfer to criminal court takes place when the juvenile court believes a juvenile poses a long-term threat to society and it would be inappropriate to place the more antisocial juvenile among other young offenders. Remember, the juvenile court is still interested in rehabilitation of juvenile offenders based on the idea that many of the juvenile offenses result from developmental factors that can be addressed in most youth. In those instances in which the criminal behavior does not appear to be amenable to change, juveniles are transferred to criminal court where they must face criminal sanctions and are more likely to be institutionalized because of the ongoing threat they pose. Nonetheless, this departure from the traditional juvenile approach is not without criticism. Many commentators believe that the process is not consistent and may be racially discriminatory (Dawson, 2000). Furthermore, the intended effect of the transfer process is to reduce recidivism in these at-risk youths and it is questionable whether transfer to criminal courts meets that objective (Bishop & Frazier, 2000). There may even be an increase in the recidivism rates for juveniles transferred to criminal courts (Shoemaker & Wolfe, 2005). Whatever the case, it does not appear that juveniles charged with the most serious offenses (e.g., murder) are treated less severely than adults. Conviction rates and sentence lengths are approximately equal for juveniles and adults charged with murder (Grisso, 1996). Furthermore, it appears that adolescents who have been convicted of murder rarely ever murder again upon their release (Grisso, 1996).

Within the context of transfer evaluations, forensic psychologists normally address a juvenile's risk for offending in the future, overall maturity, and amenability to treatment (Salekin, 2002b). However, there are not any specialized procedures or assessments that exist to guide clinicians in this process. Part of the reason for the lack of a systematic psychological procedure is the lack of clarity in regard to the legal criteria. *Kent v. United States* (1966) is frequently cited as a legal foundation for transfer criteria (Grisso, 2003c). The specific standard varies between states but generally includes waivers for public safety (16%), whether it is in the interest of the juvenile (18%), a balance of public safety and the interests of the juvenile (34%), and a specific list of the *Kent* criteria (18%) (Salekin & Grimes, 2008). As a result, concerns arise not only about the legal process but also about the psychological methods used to assist the legal decision making. Ultimately,

it is necessary to determine both the risk of the juvenile and her amenability for treatment, but the nature of the process cannot simply be described as a combination of these two processes because it necessitates a clear understanding of the context in which the juvenile will function (Grisso, 2003c).

Competency Evaluations

The competence of a juvenile was rarely an issue in the juvenile courts when rehabilitation was the focus, but as there has been recognition of the courts' more punitive stance, forensic psychologists have been called upon increasingly to perform competency evaluations. As discussed (Chapter 8), criminal competency normally focuses on ensuring that the defendant understands the proceedings and the potential consequences of any legal decisions. Competency is normally raised for juveniles in regard to competency to stand trial (Bonnie & Grisso, 2000), but also can be an issue in regard to understanding their *Miranda* rights (Grisso, 2003c). Issues related to competency become especially difficult to determine in regard to juveniles because of their immaturity and underdeveloped cognitive abilities and the disposition of a case where incompetence is due to developmental issues. However, most competency statutes do not include developmental or psychosocial immaturity as an important issue. The idea of developmental immaturity is important, because in adult criminal cases, the defendant would be held for restoration of competence but with a juvenile that may mean waiting for them to grow and mature into adulthood. Some research even suggests that many juvenile offenders, especially those under 14, are not competent to stand trial (Steinberg et al., 2003) and that psychosocial immaturity is very important in assessing the competence of a juvenile (Grisso, 2003c). One survey of mental health professional who perform these evaluations found that two-thirds had found a juvenile incompetent because of developmental immaturity (Grisso & Quinlan, 2005). As a result of the lack of legal criteria and uncertainty, there continues to be discussion about whether competency should even be raised as an issue for juveniles (Zimring, 2000b).

Ryba, Cooper, and Zapf (2003) surveyed psychologists to gather some idea of the most commonly employed methods used in these situations. In their survey by 82 forensic psychologists who had expertise in juvenile forensic assessment, there were seven areas that at least 70% of the respondents indicated as essential in conducting a juvenile competency to stand trial (CST) evaluation. These essential areas included evaluation of current mental status (95.1%), understanding the charges or penalties (95.1%), CST-related abilities (91.5%), capacity to participate with attorney (90.2%), mental illness opinion (86.6%), understanding of the trial process (85.4%), and mental illness/mental retardation/immaturity rationale (74.4%). Results were extremely similar to those found in previous research surveying forensic psychologists in regard to adult competency (Borum & Grisso, 1996). Respondents also were asked questions about the use of different psychological tests and specialized forensic tests. There was much less consensus in regard to the specific tests used even though 79% of the respondents believed in psychological testing and 70% thought forensic testing was essential or recommended in juvenile competency evaluations (Ryba et al., 2003). These results

suggest that there is some consensus in regard to the practice that occurs in juvenile competency evaluations, but there is little research to assist forensic psychologists in knowing whether these more common practices are empirically justified.

Insanity Evaluations

Another area in which it was almost unheard of for forensic psychologists to practice in juvenile court is in determining criminal responsibility or insanity. It is interesting that historically many jurisdictions have ruled that any child under 7, and even under 11 in some jurisdictions, automatically does not have the required mens rea or guilty mind in order to commit a criminal act for which they are held responsible (Tanenhaus, 2000). Nevertheless, as juveniles were afforded more due process rights and the punitive nature of the juvenile courts began to be recognized, forensic psychologists were needed to evaluate whether juveniles were insane at the time of a delinquent act.

As is the case with competency, there is little empirical basis for the evaluation of a juvenile's mental state at the time of the offense (i.e., insanity) and there are not any measures designed especially for juveniles. Therefore, it has been recommended that forensic psychologists rely on those procedures developed for adult criminals (Otto & Borum, 2003). However, the forensic psychologist has the added burden of distinguishing the delinquent behavior not only from a potential mental illness, but also the juvenile's own immaturity. Although it is clear that insanity has been raised in regard to juveniles with added frequency, it is still extremely rare (Haller, 2000). Some states have even ruled that juveniles are not entitled to an insanity defense. Furthermore, even if a state allows for the defense, many still do not have a formal process set up for handling juveniles acquitted NGRI.

Risk Assessment

A final area in which forensic psychologists are increasingly being used in juvenile courts is risk assessment. Risk assessment is of course an issue that is intertwined with other roles such as the evaluation of treatment amenability and transfer to criminal court. However, it also represents a distinct role performed by forensic psychologists in this context and can be an important issue at almost every stage of the juvenile system (Otto & Borum, 2003). Assessment of risk in juveniles is significantly different from risk assessment with adults because of the dynamic nature of youth. Juveniles are continually developing and changing and do not offer the years of stability from which clear static risk factors can be identified.

Another form of risk assessment frequently employed with juveniles is threat assessment. **Threat assessment** occurs when a juvenile comes to the attention of those in authority through certain behaviors or verbalizations that suggest he or she is a threat to commit future violence (Randazzo et al., 2006). One context in which threat assessment occurs that we will discuss in more detail later is school violence or school shootings. In this context, the forensic psychologist must evaluate whether the juvenile poses a serious threat to act out in the future because he is exhibiting certain characteristics that suggest he is following a particular developmental course.

However, the majority of risk assessments are of the traditional variety. There are several structured or actuarial instruments that have been developed for juveniles. Two of the more notable instruments are the Early Assessment Risk List (EARL) for girls and boys (Augimeri, Koegl, Webster, & Levene, 2001) and the Structured Assessment of Violence Risk in Youth (SAVRY; Bartel, Borum, & Forth, 2000). These tools are designed to identify the most relevant risk factors and then encourage the forensic psychologist to rate the juvenile on the presence of the characteristics captured in each risk factor. Although the procedures and use of structured approaches to risk assessment are similar in juveniles and adults, it is important to recognize there are differences. A forensic psychologist performing a juvenile risk assessment needs to be aware of the developmental nature of both delinquent behavior and normal juvenile behavior (Borum, 2003b). This task, combined with the lack of wide-scale empirical support for any juvenile risk assessment tool, makes it especially difficult for the forensic psychologist to perform risk assessments on juveniles.

Finally, any forensic psychologist performing these evaluations should be aware of the risk management implications (Viljoen, Elkovitch, & Ullman, 2008). It is common in these types of evaluations to make recommendations for reducing the potential for violence in an individual. As previously described, there are interventions designed to reduce juvenile delinquency and those interventions that focus on specific deficits or risk factors are generally more effective than general approaches (Lipsey & Wilson, 1998). Evaluations that highlight not only the probability for future violence but the factors likely to produce it and the type of violence likely to be perpetrated are most appropriate in these situations.

Special Issues in Regard to Juveniles: School Violence

As Borum (2000) states, "despite recent declines in the reported rates of juvenile violence, there appears to be increasing public and professional concern about violent behavior among children and adolescents" (p. 1263). Borum's quote sums up much of the current chapter and the state of the research and practice in regard to juveniles. Even though we know juvenile violence has decreased, we continue to be very interested in it, as seen in the increasing media attention and even in the call for forensic psychologists to participate more in the evaluation and treatment of youth, especially violent youth. Part of the increased attention is not just the perception where juveniles are becoming more dangerous, but that they are doing so in the location that parents thought they would be the safest, the schools. As a result of the specter of juvenile violence and juvenile murder, there have been increasing calls for more punitive approaches to handling violent juveniles.

School Violence and School Shootings

Increasing public concern about school violence largely has been fueled by and become associated with student-perpetrated shootings in such places as Paducah, Kentucky;

Box 11.3. The Virginia Tech Tragedy: Its Role in School Shootings and Forensic Psychology

On April 16, 2007, the single largest school shooting in the history of the United States took place at Virginia Tech University. Thirty-two people were killed and 25 were wounded in two separate attacks on the campus. Seung-Hui Cho, a student at Virginia Tech majoring in English, was soon identified as the shooter who took his own life when law enforcement officials closed in on him at the end of his killing spree.

The tragedy ignited a debate on a number of fronts that are relevant to our discussion of school violence. Evidence collected after the shooting clearly indicated that Cho was suffering from significant psychological problems. Cho was originally described as a loner, but evidence accumulated in the days after the incident that indicated his troubles ran much deeper. Several former professors commented that his class writings had been disturbing and at least one professor complained to administrators in her department. The University had investigated Cho for stalking two female students and in 2005 he was declared mentally ill, was hospitalized briefly, and was court ordered to seek outpatient therapy. However, Cho never followed the court's order and there was no follow-up of his case to determine if he had complied. Despite this court order questioning his mental soundness and a federal law prohibiting the sale, Cho was allowed to purchase the semiautomatic weapons he used in the shootings. The events leading up to the Virginia Teach tragedy and the deaths of over 30 people raise questions about the therapeutic interaction of the mental health and legal systems to prevent future incidents.

Jonesboro, Arkansas; and Columbine High School in Colorado during the 1990s. Fears that arose after these early shootings have only been reinforced by later shootings at Dawson College in Montreal, Canada, where one student was killed and more than a dozen were wounded and the shooting of 10 girls ranging from 6 to 13 years old at the West Nickel Mines Amish School in Pennsylvania in 2006. Of course, the horrific tragedy at Virginia Tech in 2007 (Box 11.3) has become another widely publicized example and also serves as a reminder of the potential impact of our legal and mental health system. It is even more interesting that two of these last three examples of shootings bring attention to school violence when they were either not perpetrated by students, as in the case of West Nickel Mines Amish School, or juveniles were not the intended victims, as with Dawson College. Nonetheless, these sensationalized events add more fuel to the belief that school violence, specifically school shootings, is on the rise. Even at the height of the concern in the 1990s, school shootings did not skyrocket (Cornell, 2005) and even decreased following the 1997–98 school year (National School Safety Center, 2003; U.S. Surgeon General, 2001). In fact, violent crime in general has decreased in school (DeVoe et al., 2002). Schools continue to be one of the safest places for children (Shoemaker & Wolfe, 2005) and the probability of a student-perpetrated homicide occurring at any given school is .0000781 annually (Cornell, 2005).

Nonetheless, there has been greater attention placed upon school violence and forensic psychologists have been called to assist in the process. Early prevention efforts focused on zero tolerance policies and on identifying warning signs of possible school shooters. However, concerns arose that school administrators would use these lists of warning signs to identify and punish students. It should be noted that these lists of warning signs tended to include very general items such as previous truancy, use of drugs or alcohol, and frequent displays of anger. However, not even the most successful profilers in the world, the Federal Bureau of Investigation's (FBI) National Center for the Analysis of Violent Crime, recommended profiling school shooters (O'Toole, 2000). The inappropriateness of the use of profiling is even more surprising given the so-called "profiles" of school shooters that developed after incidents like Columbine. The public received the message that school shooters were all students who had been bullied and dressed in black trench coats. This view became so popular that the FBI identified a list of prominent myths (Table 11.2) that surrounded school shootings (O'Toole, 2000).

Although criminal profiling school shooters was not deemed an effective method for preventing them, the process of threat assessment that was previously mentioned did seem to apply to these situations. Threat assessment was an approach developed by the United States Secret Service based on identifiable threats or attacks on public figures (Fein & Vossekuil, 1998, 1999). Threat assessment seems especially appropriate for school shootings because school shooters almost always tell someone about their plan beforehand and there is evidence that legitimate school shootings have been prevented because fellow students or adults have reported threats to authorities (O'Toole, 2000). Threat assessment does not cast a broad net over students like those warning lists did but instead assesses the viability of a threat because, as the FBI has suggested, not all threats are created equal and some will be completely harmless and others should be taken seriously (O'Toole, 2000). Threat assessment encourages identification of precise actions that are associated with behaving violently. For example, if a student makes a threat against a school and after an investigation it appears the student has access to weapons, has a specific plan, and has an identified target, then the threat may be credible. However, if another student makes the same threat but has not exhibited any of these behaviors, the threat may not be credible. Furthermore, preliminary research has supported the use

Table 11.2. Myths Surrounding School Shootings

School violence is an epidemic in the United States
School violence is increasing
Homicides are increasing in schools
All school shooters are alike
The school shooter is always a loner
School shootings are exclusively motivated out of revenge
Easy access to weapons is the most significant risk factor for school shootings
Students who become violent engage in a number of unusual hobbies and activities

Source: Based on O'Toole (2000) and Cornell (2007)

of threat assessment in preventing school shootings (see Randazzo et al., 2006, for a review).

The literature has progressed so far at this time that threat assessment guidelines are frequently adopted by schools in order to intervene in these potential cases and prevent any future violence, not simply predict it. One set of guidelines, the Virginia Student Threat Assessment Guidelines, have been empirically tested in hundreds of schools and found lower suspension rates and more favorable school climates as perceived by students in those schools utilizing the approach (Cornell & Allen, 2010). The Guidelines suggest a seven step plan that concludes with the implementation of a safety plan. Again, this approach with school shootings and threat assessment suggests the increasing focus not only on predicting or assessing risk but on managing the problem to prevent violence (Borum, Cornell, Modzeleski, & Jimerson, 2010).

Even though it is a myth that school violence is an epidemic, that all school shooters look alike, that they are all loners, that they all act completely out of revenge, and that they can be effectively profiled (O'Toole, 2000), homicides and violence do occur within the confines of our schools. The occurrence of even a single violent act, much less a homicide, should encourage decisive action on the part of administrators. Forensic psychologists can assist schools by educating them and performing threat assessments based on the empirical literature when appropriate.

Reflection and Review

1. Should the purpose of the juvenile courts be different than our adult courts?
2. Is juvenile crime increasing?
3. What is different about the role of the forensic psychologist in the juvenile system compared to the adult system?
4. Is there a profile of a school shooter?

Key Terms

desistors
due process
juvenile delinquency
persistors
status offense
strength-based assessment
threat assessment

Further Readings

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12 Child Custody

Chapter Objectives

1. Describe the development of child custody determinations in the law
2. Explain the different professional guidelines in child custody evaluations
3. Summarize the actual practice of forensic psychologists in child custody evaluations
4. Know the impact of divorce on children and the role of child abuse in custody cases

This chapter continues to focus on child and family issues but in a different context than the previous two chapters by examining the legal and physical custody of children after their parents' divorce or separation. Child custody may be one of the most difficult and complex issues in forensic psychology (Otto, Buffington-Vollum, & Edens, 2003) and it may be a personal and professional challenge to forensic psychologists because of the value-laden nature of these evaluations. In a child custody evaluation, a forensic psychologist must evaluate multiple people (parents, children, other potential caregivers), evaluating them in regard to numerous abilities and from multiple vantage points. These professional tasks become even more difficult with the added realization that child custody situations may invoke on a professional personal biases in regard to raising children. Although any forensic task may be influenced by one's personal biases, many argue that child custody determinations are like no other forensic task in this regard. The value-laden nature of child custody evaluations becomes clearer when we think about our own ideas regarding the types of people who are the best parents or the manner in which we think children should be raised. Do you think a two-parent household is the best way to raise a child? Are a man and a woman the best equipped to raise a child? Should children be spanked when they misbehave? Is a child better

off with a parent of his or her own race or ethnicity? Is it better for a child to go to church, synagogue, or temple or be raised by a parent who is not religious? These types of questions often address beliefs and values that everyone holds but may or may not be supported by the psychological literature. As a result, forensic psychologists who are involved in child custody decisions must be aware of their personal biases and acknowledge where their biases must end and their professional responsibilities begin. Furthermore, forensic psychologists may be less equipped and have less expertise in this area than other areas of forensic practice (Melton et al., 2007). All of these issues combine to make child custody situations extremely difficult and make it even more important that forensic psychologists are aware of remaining within their scope of practice.

It also is important to realize the frequency of these types of decisions before the courts today. It has been regularly discussed in the media that approximately half of all marriages end in divorce. However, not all married couples have children. Some research suggests that around 40% of children will experience the divorce of their parents prior to age 18 (Bumpass, 1984). Even more importantly, not all divorced couples with children will legally contest child custody. In fact, contesting the legal custody of children occurs in a minority of divorces. The best available data seem to suggest that only about 10% to 30% of cases involve legal conflict about the custody of children (Bernet, 2002; Maccoby, Mnookin, Depner, & Peters, 1992; McIntosh & Prinz, 1993).

Moreover, the courts may not accept expert testimony from forensic psychologists in child custody decisions in the same manner as they do in other cases. In previous chapters, there has been a general trend that the final decisions made by the courts are overwhelmingly similar to the conclusions reached by the consulting forensic psychologist. However, courts appear warier of opinions offered by forensic psychologists in child custody decisions. Courts may be less likely to adopt the conclusions of forensic psychologists in this area than any other area in forensic psychology (Otto et al., 2003) and generally consider psychological evaluations less critical (Felner, Rowlison, Farber, Primavera, & Bishop, 1987). Horvath, Logan, and Walker (2002) found that courts' ultimate decisions were identical to the conclusions of the child custody evaluation 27.3% of the time and similar in 63.6% of the cases. These numbers stand in stark contrast to the agreement rates we saw in earlier chapters focusing on insanity and competency decisions that were above 90%. Despite courts' potential skepticism, it also appears that forensic psychologists are increasingly being retained in these cases (Emery, Otto, & O'Donohue, 2005).

Legal History and Assumptions about Child Custody

It is important to get a clear understanding of the meaning of custody before examining the legal assumptions involved. Traditionally, the law considered children **chattel**, or personal property, that must be divided when the marriage contract terminated or a divorce occurred. Common law originally considered children just like any other form of personal property, but this practice has changed over the years so that there are

now unique aspects in awarding custody of children compared to other personal property like a couch or a fish tank.

There are several specific types of custody arrangements involving children (Hess, 2006). There is **sole custody** in which one parent is awarded custody of the children. **Divided custody** occurs when each parent is awarded sole custody at different parts of the year. For example, a mother may be awarded sole custody of the child during the school year, but then the child lives with the father during the summer. **Split custody** occurs when the custody of multiple children is split between two parents. For example, the mother may have sole custody of the daughter and the father may have sole custody of the son. Finally, there is **joint custody** where parents share custody of a child or children and both have ongoing responsibility for their care. Regardless of the specific type of custody, a parent also may have either legal or physical custody of a child. **Physical custody** means that the child lives with a particular parent and that that parent is primarily responsible for the daily care of that child. **Legal custody** refers to the ability to make legal decisions regarding a child. So, a father may have sole physical custody of a child, but the parents have joint legal custody so that both or either can make legal decisions regarding her care such as giving consent for a medical procedure. For simplicity, when we use the word *custody*, we are typically referring to physical custody or where the child lives.

Legal Standards and Preferences for Child Custody

The impact of the law for this area of practice is quite evident in some of the assumptions the law has made about who is the best parent. As previously stated, children have long been considered personal property and subject to division like any other personal property during a divorce. Originally, personal property reverted to the husband and therefore children also fell to the father (Wyer, Gaylord, & Grove 1987). However, beginning in the late 1800s the law began to adopt a new preference in awarding the custody of children, called the **tender years doctrine**.

Under the tender years doctrine the mother was considered the best parent, especially of younger children, or those in their *tender years*. The mother was considered inherently a better parent than the father because of her maternal and caring nature. Although mothers were typically considered the better qualified parents under the tender years doctrine, this legal preference could be overcome by showing the mother was unfit in some way and therefore should not receive custody of the children. This preference was adopted even though evidence clearly indicates that fathers can be as competent in their parenting as mothers (Silverstein, 1996). The tender years doctrine was the primary legal standard in most jurisdictions until about the 1970s (Hall, Pulver, & Cooley, 1996). At this time, the legal standard switched to the **best interest of the child**.

The adoption of this standard marked an important shift in the intentions of the courts. The best interest of the child standard (BICS) suggests that the rights of the parents were not of primary importance in awarding custody of children but that the awarding of custody should be based on the development and continued

maturation of the child. However, the best interest of the child standard is open to a great deal of interpretation and has been frequently criticized for its vagueness (Krauss & Sales, 2000). The Uniform Marriage and Divorce Act (1979) has been adopted by many jurisdictions. It considers a host of factors in deciding custody, but it does not assign any specific weight. These factors include (1) the mental and physical health of all individuals involved in the care of the children, (2) the adjustment of the child to their home, school, and community, (3) the parents' ability to provide basic needs, (4) interaction of the child with parents, siblings, or any other individuals, (5) the wishes of the parents and the child, and (6) any other relevant factors. Michigan's Best Interest of the Child Criteria (1970) has also been frequently used as a model list of criteria (see Table 12.1).

Research has also asked child custody experts to rate the importance of these criteria in deciding custody arrangements based on the BICS. Results reveal that emotional ties between parents and child, willingness and ability of the parents to encourage a close parent–child relationship with the other parent, and the absence of domestic violence were the most important to forensic psychologists in performing these evaluations (Bow & Quinnell, 2001). Moral fitness; home, school and community records of

Table 12.1. Michigan's Best Interest of the Child Criteria

1. The love, affection, and other emotional ties existing between the parties involved and the child.
2. The capacity and disposition of the parties involved to give the child love, affection, and guidance and to continue the education and raising of the child in his or her religion or creed, if any.
3. The capacity and disposition of the parties involved to provide the child with food, clothing, medical care or other remedial care recognized and permitted under the laws of this state in place of medical care, and other material needs.
4. The length of time the child has lived in a stable, satisfactory environment, and the desirability of maintaining continuity.
5. The permanence, as a family unit, of the existing or proposed custodial home or homes.
6. The moral fitness of the parties involved.
7. The mental and physical health of the parties involved.
8. The home, school, and community records of the child.
9. The reasonable preference of the child, if the court considers the child to be of sufficient age to express preference.
10. The willingness and ability of each of the parties to facilitate and encourage a close and continuing parent–child relationship between the child and the other parent or the child and the parents.
11. Domestic violence, regardless of whether the violence was directed against or witnessed by the child.
12. Any other factor considered by the court to be relevant to a particular child custody dispute.

Source: Based on Michigan Compiled Laws (1970)

the child; and the permanence of the family unit were the least important (Bow & Quinnell, 2001). Although the BICS may not offer definitive guidance as to the specific factors that should be considered and the weight that should be assigned to them, the standard does focus the attention back on the needs of the child, instead of the battling parties.

Additional Legal Preferences

Though rarely resulting in the development of precise legal standards, courts have also shown other preferences in awarding custody. There clearly has been a traditional preference for awarding custody to the biological parent or even biological relatives. This biological preference is clearest when the court has had to make decisions between a biological parent with a minimal or nonexistent relationship with the child and a third party with a significant interpersonal relationship with the child but no biological tie. This biological connection or blood tie has been so important in the eyes of the law that it extends even to fifth degree relatives anywhere from grandparents to great-great-great grandparents, uncles and aunts to great uncles and great aunts, and first cousins to first cousins once removed (Robbins, 1995). The courts have shown a resistance to awarding custody to non-blood relatives, even when a prior relationship existed (*Bowie v. Arder*, 1991; Langelier & Nurcombe, 1985), because they assumed a biological relative is better qualified to raise a child than a nonbiological relative. This preference may even be based to some degree on the historical treatment of children as personal property.

In addition to the assumption that biological relatives are better qualified to raise a child, other legal assumptions have been challenged as society has evolved. The courts have assumed that in cases where there is a gay or lesbian parent that the heterosexual parent is more qualified to raise the child or the homosexual parent is even less qualified than another biological relative (*Bottoms v. Bottoms*, 1995). However, more recent trends suggest that some courts are ignoring the sexual orientation of any custodial parent as orientation is unrelated to parenting ability (e.g., *Pulliam v. Smith*, 1998). Though the court specifically stated in *Pulliam* that homosexual parents receive equal consideration to heterosexual parents, the child in this case curiously was removed from the home of the homosexual parent because he was not married to his life partner and there were pictures of drag queens in the house.

Another issue the courts have addressed at times is awarding custody of children when the parents are of different races or then remarry someone of a different race. Originally, a child was placed with the parent he or she most physically resembled because the assumption was that the parent could best identify with any issues that child faced. The courts continue to struggle with this issue without a consistent trend. However, the United States Supreme Court has ruled that removing a child from a White mother because of her marriage to an African American man is discriminatory (*Palmore v. Sidoti*, 1984). It is curious that the psychological literature did not support these legal assumptions and trends and any forensic psychologists who supported these legal realities with their testimony did so without clear empirical evidence.

Child Custody Laws and Professional Guidelines

As previously stated, the dominant legal standard today for awarding custody of a child is the best interest of the child standard. Hall et al. (1996) conducted a review of all the state statutes regarding custody determination and concluded that little consensus existed regarding the factors to be considered. They noted that the most commonly listed criteria include the child's wishes (24 of 50 states); observed interaction and interrelationship of the child, parents, and other parties (17 of 50); and history of child abuse (16 of 50). As of 2004, all states had adopted some form of the Uniform Child Custody Jurisdiction Act, similar to the Uniform Marriage and Divorce Act, that included several factors to be considered when determining the best interest of the child such as the age and sex of the child; the wishes of the child; interrelationship of the child, parents, siblings, and significant others; the child's adjustment to home, school, and community; and the mental and physical health of all parties (Hess, 2006). Forensic psychologists must be aware of the precise laws in effect in their given jurisdiction regardless of any similarities or inconsistencies across different jurisdictions.

The BICS has been criticized for several reasons. First, critics have argued that there is no precise definition of the best interest of a child and therefore judicial decisions are often based on personal biases, not scientific literature or even societal notions (Schneider, 1991). It also has been argued that judges are not trained to make these determinations because they are based on a number of inexact nonlegal factors (Krauss & Sales, 2000). As a result, critics have argued that judges really use a default standard for making custody decisions, the least detrimental alternative standard (Schultz, Dixon, Lindberger, & Ruther, 1989). Scholars argue that judges use a negative standard by which the parent who is likely to cause the least amount of harm to the child is granted custody and that a formalization of this standard may provide the most useful standard (Krauss & Sales, 2000). This standard may be better because it more accurately represents the current practice of judges and societal expectations, it may be more realistic given some of the negative consequences of post-divorce relationships, psychological research is better at providing evidence of detrimental factors, and forensic evaluations based on this standard probably better represent the legitimate scope of practice of mental health professionals (Krauss & Sales, 2000). Although we will revisit some of these issues later, it is important to start thinking about the difficulties or the therapeutic consequences of the current BICS standard when the discussion turns to the practice of conducting child custody evaluations.

Professional Guidelines for Child Custody Evaluations

In addition to the legal standards that govern parental preferences, there are a variety of professional guidelines that act as a guide for forensic psychologists conducting custody evaluations. These practice guidelines do not carry the authority that the legal standards carry and their purpose is different. The legal standards specify courts' requirements or basis for legal decisions. Professional guidelines are a set of professional and ethical guidelines designed to encourage forensic psychologists to perform their role

to the highest standards of professional practice. They do not replace the legal standards but instead assist forensic psychologists in meeting the needs of the courts.

The American Psychological Association (APA) first published a set of guidelines for conducting child custody evaluations in 1994. The APA Guidelines consist of recommendations that focus on the format and process of the evaluation instead of the specific content (APA, 1994). We will focus on a few of them in more detail (see Table 12.2 for a complete list). The first Orienting Guideline specifies that the evaluation should focus on the best psychological interest of the child. This guideline is important in that it both encourages recognition of the legal standard and it encourages forensic psychologists to stay within their scope of practice by focusing on the *psychological* interest of the child. The fourth and sixth guidelines recognize the value-laden nature of these evaluations and encourage forensic experts to be objective and impartial in their evaluation and be aware of their potential biases. The seventh guideline identifies

Table 12.2. APA Guidelines for Child Custody Evaluations

I.	*Orienting guidelines: Purpose of a child custody evaluation*
1.	The primary purpose of the evaluation is to assess the best psychological interests of the child.
2.	The child's interests and well-being are paramount.
3.	The focus of the evaluation is on parenting capacity, the psychological and developmental needs of the child, and the resulting fit.
II.	*General guidelines: Preparing for a child custody evaluation*
4.	The role of the psychologist is that of a professional expert who strives to maintain an objective, impartial stance.
5.	The psychologist gains specialized competence.
6.	The psychologist is aware of personal and societal biases and engages in nondiscriminatory practice.
7.	The psychologist avoids multiple relationships.
III.	*Procedural guidelines: Conducting a child custody evaluation*
8.	The scope of the evaluation is determined by the evaluator.
9.	The psychologist obtains informed consent from all adult participants and as appropriate, informs any child participants.
10.	The psychologist informs participants about the limits of confidentiality and the disclosure of information.
11.	The psychologist uses multiple methods of data gathering.
12.	The psychologist neither overinterprets nor inappropriately interprets clinical or assessment data.
13.	The psychologist does not give any opinion regarding the psychological functioning of any individual who has not been personally evaluated.
14.	Recommendations, if any, are based on what is in the best psychological interests of the child.
15.	The psychologist clarifies financial arrangements.
16.	The psychologist maintains written records.

an issue that may be especially problematic in child custody evaluations and encourages the avoidance of multiple relationships. Multiple relationships may be more likely in child custody evaluations because it is not unusual for couples to seek marital counseling prior to a divorce or for children involved in a dysfunctional family to see a therapist. Forensic psychologists who have seen a couple, family, or child may need to excuse themselves from performing a child custody evaluation during divorce proceedings because of the potential conflict this could cause, especially for an ongoing therapeutic relationship. Although the forensic psychologist could not testify as an expert witness, she could testify as a **fact witness**.

There also are other professional guidelines that offer more substantive advice in conducting child custody evaluations and even offer specific areas to address. The Association of Family and Conciliation Courts (AFCC) and the American Academy of Child and Adolescent Psychiatry (AACAP) have both derived formal guidelines for conducting child custody evaluations. The AFCC (2006) guidelines encourage professionals to examine such areas as the quality of the parent–child relationship and the quality of parental relationships, and to assess for domestic violence. The AACAP (1997) guidelines also identify some specific practices in which child custody evaluators should and should not routinely engage. However, these guidelines have been criticized for being arbitrary, being broad, and failing to be based in the empirical literature (Otto et al., 2003). Nonetheless, all of these professional principles offer additional guidance for forensic psychologists conducting child custody evaluations.

Forensic Practice in Child Custody Evaluations

As previously stated, child custody evaluations are extremely complex and may be the most difficult forensic evaluations to conduct because of the knowledge required and their value-laden nature. As a result, it is even more important to discuss the different techniques used in these evaluations, review the literature regarding some of the best practices, and identify some of the specific difficulties in conducting these types of evaluations.

Format and Methods Utilized in Child Custody Evaluations

Bernet (2002) identifies six major steps common in many child custody evaluations. Normally, it is best if both parties agree upon a single evaluator who is appointed by the court in order to reduce the appearance of any bias. In fact, 100% of child custody experts prefer to be retained by both parents (Ackerman & Ackerman, 1997). The process normally begins with an initial meeting with both parents involved in the divorce. This meeting is used to communicate about the process; identify the expectations of the evaluator; obtain clear information about the administrative aspects of the evaluation such as marital history, court dates, and the names and information of the parties involved; obtain any necessary court orders to conduct the evaluation; and make financial arrangements. Communicating this information to the parents allows the evaluator

to identify the limits of confidentiality and obtain informed consent for all future issues related to the evaluation such as obtaining collateral information and any psychological testing that will be conducted. After the initial conference, the evaluator often meets with the parents individually. These individual sessions allow for the evaluator to obtain information from both parents without anyone else present. Typically, the sessions focus on obtaining a good social history of each parent, information regarding the development of the marriage, each parent's relationship with the child or children, and each parent's ideas regarding the appropriate custodial relationship (Otto et al., 2003).

Sessions between the evaluator and the child or children also are an important step in the evaluation process. It is important to ask the child about his or her relationship with each parent, attempt to evaluate emotional and behavioral adjustment, and assess the manner in which the child's adjustment has affected any outside relationships or activities (Otto et al., 2003). However, the nature of these sessions depends on the age and capability of the children. For younger children, it may be necessary to have the parent present initially. It also may be important to conduct more than one session to involve both parents in the process. Because of the frequently contentious nature of divorce proceedings, it is important to assess whether the child has been encouraged or coached by one or both parents. There is some disagreement about the extent to which the child's preferences should be determined and the weight children's preferences should be given. The average age at which experts in child custody believe the wishes of a child should be allowed to choose the parent is 15.1 years (Ackerman & Ackerman, 1997). No matter the weight given to a child's preferences, it is important to identify the reasons for that opinion. It is one thing for a child to express preference for a parent; it is another if that preference is based on the parent's willingness to allow the 7-year-old child to stay out all night long versus providing for basic emotional needs. In addition to an interview with the children, it might also be important to observe the child. The observation may take place in school, in other individual settings, or by watching both parents interact with the children in a natural setting like a playground or under a controlled environment such as in the evaluator's office.

Two additional steps that are commonly part of these evaluations are the collection of collateral information and psychological testing. It is important to interview or obtain records from people in addition to the parents and the child. An evaluator may need to interview individuals such as nannies, grandparents, other siblings not involved in the custody dispute, or significant others of either parent, especially anyone who may live in the home with the children. Forensic psychologists need to obtain collateral information from pediatricians, school teachers, or previous therapists. Of course, the evaluator must obtain permission from the parents before getting any outside information. Psychological testing is also a frequent part of child custody evaluations. The type of testing used in these situations varies and the parents or children may be the focus of personality, cognitive, and forensic testing specific to child custody evaluations. The specific types of testing frequently used will be discussed in the next section.

Finally, a meeting may be scheduled with the attorneys and the parents to discuss the results of the evaluation. These meetings can take place in a variety of ways and can include all parties involved or separate meetings so that the attorneys meet together

followed by individual meetings with both of the parents. These meetings can be both contentious and useful. They provide the evaluator an opportunity to explain the findings in person and answer any questions the attorneys or parents may have about the results. These meetings may be very emotional for the parents because of the stakes involved, and any evaluator should be prepared for conflict. Of course, the nature of the marital relationship should be considered prior to setting up any meeting between the parties and the format for that meeting. For example, a history of domestic violence between the parents may dictate the manner in which any feedback is delivered to the attorneys and the parents.

Surveys of Clinical Practice and Psychological Testing

The specific clinical procedures may be even more important in conducting child custody evaluations than the general format utilized when considering scope of practice issues. As in other forensic areas, there is no universally accepted best practice standard for conducting child custody evaluations. However, surveys of professionals conducting these evaluations offer some insight into the most frequently used clinical practices and have been conducted over a 20-year time span to assess for changes in the field. Keilin and Bloom (1986) performed one of the first surveys of professionals experienced in conducting child custody–related evaluations and discovered some interesting results. They found that 100% of the respondents interviewed the mother and father and that almost 99% of them conducted a clinical interview with only the child present. Fewer experts conducted observations of different family interactions. Only about 68% observed mother–child and father–child interactions, with 50% conducting formal observations of the mother and the father interacting with one another. Respondents also reported conducting school visits (31.7%) and home visits (30%) in preparation for their formal reports. Roughly 75% of them utilized psychological testing with the parent and the child. Furthermore, child custody experts rated the different procedures in the following order of importance in later research:

- a clinical interview with the parents;
- a clinical interview with the child;
- parent–child observation;
- psychological testing of the parents;
- history of the child via a parent interview;
- psychological testing of child, previous documents and evaluations;
- contact with school and physician;
- contact with relatives and significant others; and
- a home visit. (Bow & Quinnell, 2001)

Although the use of psychological testing has been infrequent in child custody evaluations and may even be increasing (Ackerman & Ackerman, 1997), there is a great deal of discussion about the relevance of psychological testing in this context (Otto, Edens, & Barcus 2000). Forensic psychologists are trained to administer, score, and interpret

psychological tests, so it seems very reasonable that they would perform these same routine clinical tasks in a child custody evaluation. However, the degree to which the intelligence of a child or parent or the mere presence or absence of some psychopathology impacts a custody determination has been questioned. Furthermore, forensic psychologists may administer these tests without much forethought in their application to the questions before the court because they are doing what they know and have been trained to do—administer and interpret psychological testing. The ambiguity present in most legal standards for child custody only adds to the likelihood that forensic psychologists will fall back on their general clinical training. It could even be argued that the desire to test is encouraged by financial considerations and the revenue generated by the time it takes to administer, score, and interpret psychological tests (Brodzinsky, 1993). Nonetheless, opinions range considerably as to the appropriateness of any or even all psychological testing in child custody decisions. Some commentators argue against the use of certain psychological tests in child custody evaluations (Weithorn & Grisso, 1987), while others encourage their widespread use (Gould, 1999).

Partially as a result of the debate in the field about the use and misuse of psychological testing, several surveys of the practice standards in child custody decisions have taken place. In their earlier research, Keilin and Bloom (1986) found that the most frequently utilized psychological tests of adults were the MMPI (70.7%), the Rorschach Inkblot Test (41.5%), the Thematic Apperception Test (37.8%), and the Wechsler Adult Intelligence Scale (29.3%). Psychological testing for children was somewhat similar with any intelligence tests (45.1%), the Thematic Apperception Test or Children's Apperception Test (39%), miscellaneous projective drawing tests (32.9%), and the Rorschach (29.2%) being the most frequently administered. Ackerman and Ackerman (1997) replicated the Keilin and Bloom (1986) study with similar results. The MMPI-II (92%), Rorschach (48%), and Wechsler Adult Intelligence Scale-Revised (43%) remained the most popular tests with the Millon Clinical Multiaxial Inventory (II or III) replacing (34%) the Thematic Apperception Test in the top four (29%) for adults. Again, there was some consistency and some change with regard to the number of respondents who used psychological testing on children in child custody evaluations. The most frequently utilized tests by respondents were intelligence tests (58%), the Thematic Apperception Test or Children's Apperception Test (37%), the Bricklin Perceptual Scales (35%), and Sentence Completion (29%).

It should be clear from the results of the different studies focusing on test usage in child custody arrangements that much of the focus has been on general clinical instruments such as ones assessing psychopathology and intelligence. However, forensic relevant instruments related to child custody decisions have been developed that more directly address the criteria commonly identified by the law as relevant to custody determination. Some of the earliest forensic relevant tests were developed by Barry Bricklin: The Perception of Relationship (PORT; Bricklin, 1989), Bricklin Perceptual Scales (BPS; Bricklin, 1990a), Parent Perception of Child (PPCP; Bricklin & Elliot, 1991), and the Parent Awareness Skills Survey (BPSS; Bricklin, 1990b). These instruments are both projective and objective measures that assess the parent–child relationship and parenting skills from the perspective of the parent and, at times, the child. Early

reviews of many of these instruments believed them to be promising (Brodzinsky, 1993), but the lack of empirical support for them in the ensuing years as well as other problems have yielded consistent criticism (Heinze & Grisso, 1996; Melton et al., 2007; Otto et al., 2000). The Ackerman-Schoendorf Scales for Parent Evaluations of Custody (ASPECT; Ackerman & Schoendorf, 1992) is the most frequently used forensic relevant instrument in child custody evaluations (Ackerman & Ackerman, 1997) but also suffers from limitations (Heinze & Grisso, 1996; Melton et al., 2007; Otto et al., 2000). Other instruments such as the Parenting Stress Index (PSI; Abidin, 1990) and Child Abuse Potential Inventory (CAP; Milner, 1986) also have been accumulating empirical support and may be useful in child custody evaluations.

Surveys of child custody experts go beyond asking about the percentage of professionals who administer a particular test though. Some have argued that child custody evaluations are extremely time-consuming (Bradley, 2003). Although early research indicated psychologists spent about 21.9 hours on each custody evaluation (Keilin & Bloom, 1986), it appears that time has increased dramatically to over 46 hours per evaluation (Ackerman & Pritzl, 2011). Ackerman and Ackerman (1997) also asked child custody experts about the criteria that are important in making their ultimate decisions. The top 10 criteria in order were:

1. one parent is an active alcoholic;
2. frequent attempts to alienate the child from the other parent;
3. exhibition of better parenting or closer emotional bond between child and parent;
4. greater psychological stability;
5. cooperation with court orders;
6. threatening to move with the child to another state;
7. more tolerant of other parent visitation;
8. actively participates in child's education;
9. exhibits significant anger; and
10. bitterness about the divorce. (Ackerman & Ackerman, 1997)

Overall, it appears that child custody evaluations are becoming more comprehensive than in the past (Bow & Quinnell, 2001). Child custody evaluators are experienced, having on average 22 years of experience, 15 years in forensic practice, and 13 years in child custody evaluations (Bow & Quinnell, 2001). Furthermore, the overwhelming majority of child custody evaluators have experience with children, adolescents, and adults (Bow & Quinnell, 2001). Forensic psychologists appear to be adhering to many of the professional recommendations. For example, 99% of experts report informing participants of the limits of confidentiality, with 88% explaining it in written form. On the whole, these results suggest that child custody evaluators are very qualified and diligent in their efforts.

Ackerman and Pritzl (2011) have published one of the most recent surveys of child custody evaluators and compared results to Ackerman and Ackerman (1997) and Keilin and Bloom (1986). They found several significant changes over the years, including a

50% increase in the amount of time devoted to performing a custody evaluation and almost a 300% increase in hourly fee over 20 years. Participants reported a greater use of psychological testing across intelligence tests, objective and projective measures of personality, and specialized forensic instruments across children and adults, the exception being the use of the TAT among children.

Despite indications of overall competence in the field, there remains room for significant improvement. Horvath et al. (2002) took a different approach to much of the earlier research that asked child custody evaluations about their typical approaches to conducting child custody evaluations. Instead Horvath et al. (2002) examined the evaluations themselves. They found that in keeping with APA standards most psychologists used multiple methods for gathering information (84.3% at least two, 58.8% at least three, and 33.3% at least four). The majority of the evaluators assessed the psychological and developmental needs of the child (80.4%). Overall, results found that in practice there is considerable variation in the frequency in which critical factors are addressed in these evaluations and therefore some disagreement with previous research that asked for child custody experts about their routine practice. Horvath et al. (2002) suggest these differences may represent the differences between actual practice and the best practice standards experts are likely to admit to or encourage. Also, in contrast to previous research and scholarly opinion, Horvath et al. (2002) suggested that attorneys and judges are placing importance on the recommendations of the evaluations. In total, the results suggest there is still room for improvement in the routine practice of conducting child custody evaluations and that there should be continued evaluation, encouragement, and education of the best practice standards. Overall though, it appears that forensic psychologists are doing a credible and increasingly better job in these difficult circumstances.

Difficulties in Child Custody Evaluations

It should already be clear from our prior discussion that child custody evaluations are some of the most difficult, if not the most difficult, evaluations undertaken by forensic psychologists for several reasons. It is one of the few forensic evaluations where the forensic psychologist must evaluate multiple people that are central to the legal question. This process is not a matter of only gathering collateral information from multiple sources and interviewing multiple people, which should be part of all or most forensic evaluations. In child custody evaluations the examiner is actually evaluating multiple people including potentially several children along with their parents and their parents' partners (Otto et al., 2003).

The breadth and depth of knowledge necessary for conducting child custody evaluations is significant. Someone who conducts child custody evaluations must be an expert not only in adult mental health but also childhood psychopathology, normal childhood development, child abuse and neglect, substance abuse, domestic violence, alienation and remediation plans, family dynamics, parenting plans and types of custody, types of parent communication, and parenting practices (Zimmerman & Hess, 2009). An evaluator must be skilled in a variety of assessment methods and be able to synthesize this

information from multiple people in a clear and focused manner. Furthermore, forensic evaluators frequently suffer from a lack of empirical information in a number of different areas involving child custody evaluations (e.g., best custody arrangements for children) that make it even more difficult and raise the issue of the scope of practice limitations (Melton et al., 2007).

Not only is there a lack of empirical information regarding many of the areas involved in child custody evaluations but the standard psychological tests are often inadequate and forensic relevant instruments are no better at addressing the legal question. For example, it is not clear the extent to which psychopathology and intelligence are important constructs in determining child custody and their relationship to parenting skills. Family law attorneys even rate the use of psychological testing on parents and children as the least important component of a report (Bow, Gottlieb, & Gould-Saltman, 2011). Though there are a number of forensic relevant instruments for child custody evaluations, they have been routinely criticized as inappropriate, ill-conceived, or severely lacking in empirical support. However, this book highlighted similar criticisms about other areas of forensic practice (e.g., insanity), so it is unclear whether these instruments are inferior to efforts in other areas of forensic practice.

Another difficulty with conducting child custody evaluations is their value-laden nature. The nature of custody disputes leads to an evaluation of parenting practices and a suggestion, subtle or overt, as to the best parenting practices. An evaluator and the court are in a position to censure a parent for spanking their children, allowing them to stay up too late, allowing them to watch too much television, or a host of other serious questions that parents routinely struggle with in raising children. A forensic psychologist may have a tendency to fall back on personal values, experiences in their own family of origin and biases in determining a forensic opinion (Zimmerman & Hess, 2009). A forensic psychologist should be aware of certain hot-button issues such as domestic violence or infidelity. These issues may or may not be related to the forensic opinion but certainly should only be given the appropriate weight and not unduly influence the evaluator. The question remains though whether custody evaluations are all that unique in this concern.

Child custody evaluations tend to be extremely conflictual for the psychologist as well as the other parties involved. There are two parties that are obviously fighting over their child or children, and divorces are frequently very emotional situations. In addition, a forensic psychologist may be the person whom one party or even both parties blame for an unfavorable custody arrangement. As a result, forensic psychologists who perform custody evaluations are frequent targets of ethical complaints and malpractice lawsuits (Benjamin & Gollan, 2003). Ackerman and Pritzl (2011) found that almost half of child custody evaluators had at least one licensure complaint filed against them, about 20% had three or more filed against them, and 19% had malpractice suits filed against them. Any psychologist thinking of practicing in this area should be aware that it is likely that he or she will be confronted with these situations.

The final difficulty that is a combination of many of the difficulties already discussed is the potential for child custody evaluations to fall outside the scope of practice of forensic psychologists. As discussed before, the legal standards for child custody

evaluations are often criticized as problematic because they are frequently ambiguous or fall outside the expertise of psychology. Psychologists are not trained to determine the ability of parents to provide for the physical needs of children and many question the role that the psychological concepts that psychologists can assess (psychopathology and intelligence) should play in these evaluations. As a result, psychologists themselves have questioned whether forensic psychology has anything unique to offer the courts in these situations (Otto et al., 2003). Some have even argued that these situations fall outside the expertise of psychology because of the limitations of the research and the legal questions that are being asked. Furthermore, Bow et al. (2011) found that only 56% of family law attorneys are at least *satisfied* with the job that child custody evaluators do.

Because of the difficulty both inherent in the custody evaluation process and the limitation of the relevant research, Emery et al. (2005) identified three reforms. First, they encouraged parents to reach agreements regarding child custody by other means than directly contesting it. Mediation, negotiation, therapy, and other means are encouraged prior to any adversarial approach. Mediation is described more fully later in this chapter. Second, they believe that legislatures should improve on the current standards for determining child custody by providing more definitive criteria that would even further narrow the practice scope. Emery et al.'s (2005) final recommendation is to limit expert testimony in the area. This can be achieved by forensic psychologists making a greater effort to only offer conclusions that are empirically based and to avoid moving beyond the available scientific literature, expanding professional guidelines, and utilizing the existing laws governing the admissibility of expert testimony. They go so far as to argue for a ban of any forensic relevant tests and argue for cautious use of general psychological tests applied to this area.

However, you should not get the idea from this chapter that child custody evaluations are without merit. Though the difficulties involved in conducting child custody evaluations may be significant, many of the criticisms of child custody evaluations are similar to the concerns raised about other areas of forensic practice. Even if you accept the criticisms fully, one question remains. Who would assist the court in deciding the best interest of the child if not mental health professionals? A plumber? As long as the courts are aware of the limitations of forensic practice in this area, which forensic psychologists should be making them aware of, the courts can assign the appropriate weight to the expert's reports and testimony in making their final legal decisions. Moreover, there has been a continuing call among experts in the field for a reform of practices and the need for research to better assist forensic psychologists in this area (Austin, 2009; Kelly & Ramsey, 2009).

Effects of Custody and Divorce on Children

In addition to the practice issues involved in child custody disputes, forensic psychologists conducting these evaluations should also be aware of the impact that divorce may have on children and the influence of different custody arrangements (see Figure 12.1).

David De Lossy/Getty Images

Figure 12.1. The marital conflict that often accompanies divorces and custody disputes can have a significant impact on the development of the children involved.

There is a great deal of misinformation regarding the role of divorce and custody on the development of children. This misinformation may be the result of value-based judgments as well as early research that had limited application because of methodological flaws. It is important for any forensic psychologists to have a thorough understanding of these issues when conducting custody evaluations.

Effects of Divorce on Children

Whether because of methodological limitations of the early research or the social stigma attached to divorce, initial research focusing on the developmental impact of divorce on children was fairly clear. The research consistently suggested that children from divorced families suffered from a host of academic and emotional difficulties that children from intact families did not experience (Kelly, 2000). An earlier meta-analysis even suggested that these differences only increase with age (Amato, 2001). Wallerstein and Blakeslee (1989) conducted a 15-year longitudinal study of 131 children and adolescents whose parents divorced. The results were very damning regarding the impact of divorce on the later development of the children who were a product of these marital relationships. They found that nearly one-half of the children were anxious, underachieving, and sometimes angry as adults and that only one-tenth of them were relieved after the divorce occurred. Furthermore, they described a sleeper effect for the girls that was

characterized by a childhood of seemingly normal adjustment but that was followed by an adulthood in which female children of divorce were more likely to experience heightened levels of anxiety and betrayal. These women were more likely to be promiscuous and involve themselves in a pattern of unfulfilling relationships in order to protect themselves from emotional rejection and abandonment (Wallerstein & Blakeslee, 1989). However, this study is a good example of the flaws in some of the early research of divorced children. The participants were recruited through offers of counseling that probably skewed the eventual study participants to those having the most difficulty adjusting to the divorce without consideration of the degree of conflict among the parents of these children. Basing our conclusions about the impact of divorce on only these types of participants would be similar to our discussion of elevated prevalence rates for domestic violence in clinical samples (see Chapter 10).

Additional research has suggested that there are some important factors to consider in describing the general impact of divorce on children. It appears that the negative impact of divorce is because of the level of conflict and the poor relationships between the involved parties, not the divorce itself. The frequency and intensity of the conflict, the nature of the conflict (e.g., presence of domestic violence), the manner in which the conflict is resolved, and any protective buffers that exist to reduce the potential negative impact are all important in determining the impact of divorce on children (Otto et al., 2003). Overall, it appears that the negative effects of divorce are due to the conflict between the parents and the parents and the children. A study by Cherlin et al. (1991) found three factors that were central to the negative effects of divorce. Children who grew up in a low-functioning or poorly functioning family were more likely to exhibit adjustment difficulties. The more severe and protracted the conflict was within the marriage, the greater the adjustment difficulties for the children. Finally, the greater the emotional upset, reduction in parenting capacity, and extended the conflict post-divorce, the greater the adjustment difficulties that children were likely to experience (Cherlin et al., 1991).

The literature generally suggests that children of divorce suffer from emotional, social, and academic difficulties more often compared to children who have not experienced a divorce, especially immediately after the divorce. These differences appear smaller than were originally believed, and the majority of children of divorce develop into normal, healthy adults. Furthermore, marital conflict is a stronger predictor of adjustment than is divorce itself. The inconsistencies in the literature appear to be the result of the variety of ways in which the issue has been studied.

Impact of Custodial Arrangement

The best custody arrangement has long been debated in the law and in psychology. Originally, sole custody was favored because of the stability it provided for children. Sole custody avoids the continued conflict divorced couples may be experiencing. More recently joint custody has been the default form of custody, but the debate continues as to the best arrangement for the children as well as the parents. The argument is that children involved in joint-custody situations are likely to experience better relationships

with the parent they do not normally reside with and parents will have to cooperate more with one another for the benefit of the child. Ultimately, the research examining the best custodial arrangement has been inconsistent.

Some research suggests that larger, better designed studies have found few differences between children who were the product of sole versus joint custody (Johnston, 1995). A meta-analysis conducted by Bauserman (2002) concluded that children in joint physical or legal custody were better adjusted than children in sole custody as indicated by better general adjustment, improved family relationships, increased self-esteem, better emotional and behavioral adjustment, and improved divorce-specific adjustment. However, there are many variables such as family income, education, and regularity of support payments that may be confounding variables in some of the research. Gunnoe and Braver (2001) controlled for 20 of these such variables and found that joint-custody arrangements have led to greater visitation with fathers, reduced maternal satisfaction with the custody arrangement, more maternal repartnering, and in general fewer adjustment difficulties. Nonetheless, not even this research has resolved the issue. Bauserman's (2012) more recent meta-analysis further found that joint-custody arrangements resulted in equivalent or better outcomes than sole-custody arrangements in regard to the relationship between the father and child, parenting stress, overall parental conflict and future litigation, and overall adjustment. However, satisfaction was actually highest for both mothers and fathers in sole-custody arrangements, followed by joint custody and noncustodial parents.

Though the issue is not definitively resolved, there is a good argument that the custodial arrangement should not be an automatic default to either joint-custody or sole-custody arrangements. The type of custody should be based on the parties involved, both in terms of the parental relationship and the effect this relationship is likely to have on any child. Maccoby et al. (1992) suggested that joint custody may be better for children in which the parental conflict is low and sole custody may lead to fewer negative consequences for children where there was significant conflict between the parents. It appears that children who come from families with significant post-divorce conflict that experience more physical custody transitions exhibit greater emotional and behavioral difficulties, especially among girls, than children in sole-custody arrangements but also from families with significant post-divorce conflict (Johnston, 1995). As with any of the negative effects associated with divorce, it appears that ongoing parental conflict is at least an important variable to consider when determining the custodial arrangement.

Positive Post-Divorce Outcomes

In addition to the factors related to emotional and behavioral problems in children following a divorce, no matter the custodial relationship, there are also factors related to positive outcomes. Emery (1999) identified four factors related to positive adjustment in children following a divorce. He found that a good relationship with an authoritative parent who the child lived with, a positive relationship with an authoritative parent who the child does not live with, minimal parental conflict that does not involve the child, and financial security were all related to positive adjustments for children.

Mediation is increasingly being selected as one option that can assist in reducing the level of conflict during divorce proceedings. Mediation usually involves a negotiation process that is overseen by a neutral third party. Research examining parents who choose to mediate child custody disputes instead of fighting legally for custody has uncovered that parents report being more involved in the children's lives, more contact with the children, greater influence in co-parenting more than a decade after the divorce, and generally being more satisfied with the arrangement than parents who did not pursue mediation (Emery, Laumann-Billings, Waldron, Sbarra, & Dillon, 2001). It appears that mediation may actually increase parental involvement while failing to increase the parental conflict associated with greater parental contact. In fact, there have been calls for the use of alternate dispute resolution approaches as a first option and child custody evaluations as an option of last or at least next resort (Silver & Silver, 2008).

Child Abuse

Although child abuse is certainly not an inherent part of custody disputes, it is an important issue that forensic psychologists need to be well versed in when performing child custody evaluations (Koch & Douglas, 2001). Psychologists should assess for abuse in part because allegations often arise in child custody disputes and attorneys are more likely to seek custody evaluations if there is an allegation of physical or sexual abuse (Waller & Daniel, 2005). Nonetheless, it does not appear that allegations of abuse or actual abuse are common in child custody disputes. In a review of over 600 child custody cases only 3% contained an allegation of sexual or physical abuse (McIntosh & Prinz, 1993), but it also has been suggested, however, that the number of allegations has risen, especially sexual abuse allegations (Gardner, 1994). Specifically, forensic psychologists who routinely perform child custody evaluations have anecdotally suggested there has been an increase in instances where a spouse has claimed that the other spouse frequently views online pornography and thereby is posing a greater risk for sexual abuse of the child. However frequent, it is very important to get an accurate assessment of whether an allegation is true or false because of the long-term impact on the child, if true, and the impact on the relationship between the child and the accused parent, if false.

Child abuse in general is a significant problem. There are over a million substantiated incidents each year and it is believed that this figure is an underestimation of the true prevalence rate by as much as one-third (U.S. Department of Health and Human Services (DHHS), 1995; Warner & Hansen, 1994), although there are more recent indications that there has been some decline in actual rates of abuse (Jones, Finkelhor, & Halter, 2006). In addition, there are numerous immediate and chronic consequences to child abuse including reduced academic performance, perceptual-motor deficits, substance abuse, suicidal behavior, and general emotional or psychological disturbances (Lutzker, 2000). Child abuse becomes even more dangerous when the intergeneration transmission of violence, discussed in Chapter 10, is considered in that as many as 70% of abused children are likely to abuse their own children (Malinosky-Rummell & Hansen, 1993).

As a result of the seriousness of child abuse allegations, it is important for forensic psychologists conducting child custody evaluations to perform comprehensive assessments of child abuse, especially when an allegation has been made. One of the dangers in assessing child abuse is that there has been a rise in the instances in which syndrome evidence relating to child abuse has been introduced in court to prove the existence of child abuse. In particular, Parental Alienation Syndrome (PAS) is often identified as a form of child abuse inherent in many child custody conflicts. PAS is described as "a disorder that arises primarily in the context of child custody disputes. Its primary manifestation is the child's campaign of denigration against a parent, a campaign that has no justification. It results from the combination of a programming (brainwashing) parent's indoctrinations and the child's own contributions to the vilification of the target parent" (Gardner, 1998, p. 77). Furthermore, the originator of the construct, Gardner, has identified eight symptoms: (1) campaign of denigration against the targeted parent, (2) frivolous, weak, or absurd rationale for alienation of the targeted parent, (3) lack of ambivalence for parents, (4) lack of guilt or remorse about the alienation, (5) use of borrowed scenarios from the alienating parent, (6) assertion that the alienation is the child's decision or independent thinker phenomenon, (7) taking the alienating parent's side in the conflict, and (8) spread of alienation to the extended family of the targeted parent. See Box 12.1 for a discussion of the controversy surrounding PAS.

Box 12.1. Focus on Research: PAS: Science or Pseudoscience?

Gardner identified this construct to explain instances in which one parent was alienated from the child by the other parent's continued berating of the other parent. For example, the actor Alec Baldwin has claimed that he is a victim of PAS at the hands of his ex-wife, actress Kim Basinger. Their contentious custody battle made headlines again in 2007 after a recording of Baldwin yelling and calling his daughter names on her voice mail was released to the public and the media. PAS or PA, as it is sometimes called, is considered a form of child abuse by many at the hands of the alienating parent. PAS is unusual in that there has been both widespread acceptance of the idea but also a great deal of controversy over it. Controversy has occurred over PAS because of many of the same issues we discussed about syndrome evidence. There have even been calls for banning the use of the term and any accompanying expert testimony in child custody cases because of the lack of empirical support for several aspects of PAS.

Nonetheless, PAS is increasingly being used in contentious custody battles to explain the poor relationship between a child and one of their parents. Currently, PAS is not listed in the DSM-5. Proponents claim that PAS is an important consideration in child custody evaluations and that because of its relatively recent identification, the PAS literature is naturally young. Opponents claim that simply having a name for something does not mean it exists and that the overwhelming majority of the literature on PAS is theoretical and descriptive, not empirical. One survey of professionals in the literature revealed that only 16.2% believed that PAS definitely met *Daubert* criteria and only 33.7% believed it should be included in the DSM (Baker, 2007). The use of PAS raises the question about the degree of empirical support necessary before forensic psychologists use it in legal proceedings.

As you may remember from our earlier discussion, an expert may inappropriately testify to an alleged perpetrator exhibiting several characteristics of child abusers and then conclude that the perpetrator must have abused the child. These characteristics may include a dysfunctional family of origin, impulsivity, feelings of inadequacy, poor judgment, and substance abuse, among others (Gardner, 1994). Although these characteristics may be more common in abusers, they may be common in a variety of people. Their presence does not conclusively indicate that they have abused a child, much less the child in question. Allegations of child abuse pose a problem because it may be the word of a child against that of an adult without any other indications.

Although most psychologists do not follow specific guidelines for investigations of abuse, even sexual abuse, there are some more accepted approaches (Bow, Quinnell, Zaroff, & Assemany, 2002). Bow et al. (2002) asked experts for their standard approaches in instances where there had been an allegation of sexual abuse. Experts rarely used specialized instruments in these cases and sometimes used inappropriate approaches. As a result, Bow et al. (2002) presented many detailed recommendations focusing on the role of the evaluator, records reviews, assessment of the allegations themselves, specific procedures to utilize, interviewing the victim, the use of appropriate psychological testing, assessing the alleged perpetrator's sexual history, observing the parent and child together, collecting collateral information, and analyzing the myriad of data that the evaluator may have assembled. Bow et al. (2002) devised one of the first comprehensive models for the assessment of sexual abuse as a result.

Reflection and Review

1. Why are child custody evaluations value-laden?
2. What is the best legal standard for determining custody of children?
3. What factors do forensic psychologists use in child custody evaluations?
4. How relevant is child abuse in child custody cases?

Key Terms

best interest of the child
chattel
divided custody
fact witness
joint custody
legal custody
mediation
physical custody
sole custody
split custody
tender years doctrine

Further Readings

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13 Personal Injury and Discrimination in Civil Law

Chapter Objectives

1. Summarize tort law
2. Explain the role of the forensic psychologist in personal injury claims
3. Know what workers' compensations claims are in the forensic context
4. Describe the practice of forensic psychology in sexual harassment claims

As you open the final chapter of this book, you have already read a lot about some of the foundational aspects of forensic psychology. In the first section of the book, you became familiar with forensic assessment, treatment, consultation, and expert testimony. You have read about forensic psychology practices that are a significant part of violence and the criminal law (psychopathy, sex offenders, and violence risk assessment) and those aspects that focus more on mental health law (insanity, competency, and civil commitment). In the fourth section of the book, you read about child and family issues involved in forensic psychology. In this final chapter, the focus is on some often neglected and less sensationalized aspects of forensic psychology. Nonetheless, these issues may constitute the largest slice of forensic practice. The bulk of our previous discussion has centered on criminal aspects of forensic psychology, with significant exceptions, but in this final chapter all the attention is directed squarely on civil aspects of forensic psychology.

The broad area of personal injury lawsuits and employment discrimination are increasingly becoming the focus of forensic psychology and pose a variety of unique challenges to forensic psychologists. One issue is that these areas are firmly embedded in civil law. The civil system, just as the criminal system, is highly influential on the consumption and practice of forensic psychology, and the precise legal requirements in the civil law may make it even more so.

Second, there are a variety of aspects of civil law that a forensic psychologist must be familiar with when conducting such wide-ranging evaluations as worker's compensation claims, independent medical evaluations, sexual harassment, or any employment discrimination claims. At a very basic level, knowledge of tort law is critical, but awareness of the differences between negligence, intentional torts, and strict liability also is important. Forensic psychologists must be especially aware of the differences between therapeutic and forensic assessments that we discussed in Chapter 2 and the importance of assessing for malingering. Finally, forensic psychologists should be mindful of their scope of practice and not fall into a false sense of security by overestimating the degree to which a certain standard assessment or treatment method may apply to a given situation. Overall, these civil forensic issues provide an exciting opportunity for forensic psychologists to make a significant impact on the legal system.

Legal Bases for Personal Injury Cases: Torts and Civil Law

The framework for much of civil law is contained in the legal concept of torts or tort law. **Torts** are a civil wrong, not a criminal wrong, that one person commits against another and results in either physical or psychological damage. There are a host of terms used to designate psychological injury such as pain and suffering, emotional damages, emotional distress, and emotional harm. There are generally four elements that constitute a tort and imply whether there is a basis for a civil lawsuit that may result in a more positive outcome by compensating someone who suffers an injury. There must be a duty or obligation, a violation of that duty, and damages occuring because of the violation, and the violation must be the proximate cause of the damages (Greenberg, 2003).

The presence of a *legal duty or obligation* is the first element of a tort (Douglas, Huss, Murdoch, Washington, & Koch, 1999). A legal duty requires that people conduct themselves in a certain manner or risk being the subject of a lawsuit. As members of society, we all owe legal duties that we do not think about on regular basis. Homeowners owe a duty to keep their property maintained (e.g., shovel snow off of sidewalks) so that guests do not injure themselves. We all owe a duty to our fellow drivers to operate an automobile in a responsible manner. If someone crossed into oncoming traffic or fails to use their turn signal, they have violated that duty and open themselves up to a lawsuit if they caused an accident, as well as possible criminal sanctions. This first element is of little importance to the forensic psychologist, but it is paramount from a legal standpoint.

The second element of a tort is that a *violation of that duty* has occurred (Douglas et al., 1999). There are several issues that are relevant in uncovering whether a duty has been violated and the nature of that violation. Negligence, intentional torts, and strict liability are three legal categories that are relevant to the second element of a tort. **Negligence** occurs when an individual fails to act in a reasonable manner to avoid violation of a duty. Negligence does not involve a determination of intent or a person's thought process but only involves their conduct. For example, Adam owes Leah a duty

to avoid running her over as she crosses the street near campus. That duty seems reasonable. However, let's say that Leah is talking on her cell phone and not paying attention as she jumps into oncoming traffic. If it is a matter of negligence, the question becomes whether a reasonable person would have hit Leah under those circumstances. If a reasonable person would not have hit her, Adam has violated the duty. It does not matter if he intended to hit her or not. However, some torts are **intentional torts** where intent is key and the consequences of the behavior are not. Assume Adam was walking around shooting his squirt gun on the sidewalk and was unaware that Leah was walking in his direction until he happened to squirt her new Christmas sweater. For an intentional tort to apply, Adam would have had to either intend to squirt Leah or know it was substantially likely that someone would get hit if he continued to shoot at things. Actions that constitute **assault** and **battery** are common intentional torts. **Strict liability** is an area where it is not important to prove the conduct was wrong but only that someone was doing something dangerous. Leah is scared that Adam is going to come after her again and squirt her out of revenge for her filing a lawsuit against him. As a result, she has decided to store some explosives in her car. Leah is not an explosives expert and has no idea of their unstable nature. Tamika happens to walk by Leah's car in a parking lot one hot day and the unstable explosives go off, injuring Tamika. Leah could be held strictly liable for her behavior and Tamika could sue her.

It is the third and fourth elements of a tort where a forensic psychologist is useful to the court. The third criteria necessary for a tort to occur is that there must be some *injury or damage*. Originally, this criterion meant some form of physical injury, so unless Leah received an eye infection from Adam originally squirting her face, she would not suffer any real damage from getting a little wet. However, the law now recognizes psychological injuries or pain and suffering as recoverable damages in tort cases. Damages can come in the form of economic or noneconomic damages (Van Dorsten & James, 2002). Economic damages consist of a loss of past or future wages or medical expenses because of the resulting injury. Noneconomic damages include physical or emotional pain and suffering and even though there is not a direct dollar value attached to a specific amount of pain and suffering, the courts must attach a dollar value to them in order to compensate the victim. Most legal systems do not allow the prevailing plaintiff to inflict an equal amount of pain and suffering upon the losing defendant so financial compensation is the normal method of compensation.

The fourth and final element of a tort is that the damage must be the proximate cause of the violation of the original duty. Proximate cause is the primary, immediate or substantial cause of the damage. Sometimes the *but for* test is used in these instances. But for Adam squirting Leah's face, would she have suffered an eye infection that caused her to lose her right eye? If no, Adam's action is the proximate cause. However, if Leah subsequently washed her contact lenses in dirty tap water it could be argued that an organism in the tap water caused the later infection, and not Adam's squirt gun. In order to be compensated for the violation of the duty that caused a particular injury, the original action must be the proximate cause.

In tort cases a plaintiff can either be awarded compensatory damages or punitive damages. **Compensatory damages** are the norm and suggest that the defendant needs

Box 13.1. *Liebeck v. McDonald's Restaurants*: The Lightning Rod for Tort Reform

Liebeck v. McDonald's Restaurants, or the McDonald's coffee case as it is more commonly called, was a lawsuit in the early 1990s that made national headlines. It was routinely reported at the time that Stella Liebeck was an elderly woman who had spilled McDonald's coffee on her lap as she left the drive-thru window at a McDonald's restaurant. It was also subsequently reported that she sued McDonald's and was awarded millions of dollars as a result. This case was frequently identified as another example of an out-of-control jury that awarded an excessive amount of punitive damages to a plaintiff. Many states have argued that by eliminating, or putting caps on, punitive damages these out-of-control civil awards could be avoided. However, the public heard only part of the story in this case.

There are a number of aspects to the case that went unreported in the popular press or received little attention. First, Mrs. Liebeck was not trying to manipulate the coffee or pour in cream and sugar as she drove away. The driver of the vehicle actually pulled over as she tried to prepare her coffee in the passenger's seat. Second, her injuries were significant. She received third-degree burns on her thighs, buttocks, and groin; was hospitalized for over a week while she underwent skin grafts; and was treated for 2 years afterward. Third, she originally requested $20,000 to compensate her for medical expenses and attorney's fees and McDonald's refused, offering only $800. Her attorney also offered several other settlements prior to trial, but McDonald's refused each one. Fourth, McDonald's had been warned repeatedly about brewing their coffee at an excessively high temperature and had received hundreds of complaints over the years. Finally, the original jury award was reduced from $2.9 million to $640,000. Nonetheless, this case continues to be incorrectly used as an example of the out-of-control jury awards involving punitive damages.

to compensate the plaintiff for the injury he suffered. Compensatory damages are supposed to make the plaintiff whole after he or she has been damaged. In contrast, **punitive damages** are intended to punish the defendant for his behavior, not simply assist the plaintiff in restoring him to a previous level of functioning. Punitive damages may be awarded in some cases where the plaintiff's conduct was especially appalling or reprehensible. Punitive damages have come under some criticism because many blame the awarding of excessive punitive damages as an indication that the U.S. civil system is out of control and that juries award an excessive amount of money for minor incidents. In fact, approximately a half a dozen states do not allow for punitive damages but only compensatory damages. Box 13.1 describes a lawsuit that is often cited as an example of these excessive jury awards.

General Forensic Practice in Personal Injury Cases

As with other aspects of forensic practice, the law establishes the foundation for the clinical work that will assist the courts in addressing the issues before them. In personal

injury cases, it is very clear that the most important tasks for forensic psychologists stem directly from the tort elements. Greenberg (2003) identified basic tasks of forensic assessments in personal injury cases. First, the forensic psychologist must establish a baseline or premorbid level of psychological functioning. This task is a bit like evaluating insanity in that it is retrospective. Second, the nature and severity of any distress must be determined. Third, the forensic psychologist must determine the extent and severity of any impairment in functioning. Fourth, the psychological cause of the impairments must be determined. Fifth, the psychological interventions that may reduce the psychological injury should be determined.

These tasks clearly follow from the previously described elements. The forensic psychologist must go back in time to try to determine the patient's level of psychological functioning prior to the incident in question before she can compare an individual's current functioning to determine if any injury has occurred. The nature and severity of the distress and psychological injuries goes directly to the presence of damages and the resulting compensation. The psychological cause of the impairment goes to establish whether the incident was the proximate cause of the distress or injury. The nature of any interventions that can reduce or alleviate the emotional injuries is important for arriving at the damages that would be appropriate to make the plaintiff whole or compensate him for economic and noneconomic damages.

It is also important to recognize the differences between forensic and therapeutic assessments that we identified in Chapter 2. Awareness of these differences may be even more important in personal injury cases. For example, our prior discussion of the nature of the client is relevant to personal injury cases. Referrals in these instances may come from private attorneys, as they do in many other issues we have already discussed. However, physicians also may be the source of many personal injury referrals (Walfish, 2006). In these instances, a physician may refer a patient she is seeing to a psychologist in order to determine if there is a psychological basis for any symptoms the patient is reporting to the physician. This referral comes before any legal action and is an additional consultation between the physician and the psychologist. Though the information is being shared directly with the referring physician and maybe even an outside attorney, if one is involved, the patient is the client because the client is the one who is contracting with the psychologist for services. Of course, the other differences between therapeutic and forensic assessments also apply to personal injury evaluations and the potential financial gain in these cases also provides the client with certain incentives to present themselves in a certain manner.

Malingering in Personal Injury Cases

Financial incentives in personal injury cases may be so great that there is a heightened risk for malingering or exaggeration. There is also a difference between malingering and exaggerating. Malingering is conscious and intentional, whereas exaggerating may be neither. The *Diagnostic and Statistical Manual for Mental Disorders* (DSM-IV TR; APA, 2000) specifically warns of malingering in these types of evaluations. However, it is not clear whether malingering is a greater concern in personal injury cases than other

forensic situations. McLearen, Pietz, and Denney (2003) stated that malingering rates vary significantly in civil psychiatric settings and reviews of the literature suggest that anywhere from 2% to 64% of personal injury claimants malinger brain injuries. In one study, Lees-Haley (1997) found that 20% to 30% of personal injury plaintiffs exhibited possible malingering. Furthermore, it appears that receiving financial compensation is related to reports of increased pain and poorer treatment success in patients with chronic pain and head injuries (Binder & Rohling, 1996; Rohling, Binder, & Langhinrichsen-Rohling, 1995). These findings were even more pronounced in those individuals with the least severe injuries (Rohling et al., 1995). Lees-Haley (1992) reported that neuropsychological patients, evaluated as a part of personal injury claims, reported high rates of complaints associated with neuropsychological injury. The majority of them identified the injury associated with the claim as the cause of their symptoms, despite the myriad of other potential causes and the mild nature of the symptoms (e.g., headaches, concentration problems, irritability).

Moreover, there is evidence that attorneys frequently coach their clients in an attempt to get them to beat psychological and neuropsychological tests. One study reported that 75% of attorneys provide information to clients about the tests they would take and the way they should respond (Victor & Abeles, 2004). Not only do attorneys admit to coaching witnesses, but almost 50% of practicing attorneys believe they should always or usually inform clients of the validity scales designed to detect malingering on many psychological tests (Wetter & Corrigan, 1995). The available evidence suggests that coaching does make clients appear more impaired in terms of neuropsychological impairments and mental illness, but psychologists can detect most coached individuals (Victor & Abeles, 2004). From a psychological perspective, coaching a witness is completely unethical, but preparing a witness is completely appropriate. Nonetheless, coaching a witness or improperly influencing his or her testimony is seen as unethical by the American Bar Association (ABA, 2006). The question still arises: when does preparing a witness cross the line into coaching a witness? Legal scholars admit that coaching witnesses may be the dirty little secret of trial lawyers (Gersham, 2002).

Furthermore, psychological experts may even influence clients' exaggeration of symptoms in personal injury cases. Williams, Lees-Haley, and Djanogly (1999) identified cases in which a psychiatrist gave a copy of the diagnostic criteria for PTSD before assessing the client and a psychologist verbally described the symptoms of PTSD to a group of clients before they were administered a psychological test. Even repeated questioning by a health care professional(s) or expectations of an evaluator can increase the likelihood of a client reporting certain symptoms (Williams et al., 1999). As a result, forensic psychologists should be especially mindful of assessing for malingering when evaluating personal injury claims.

As mentioned in Chapter 2, there are several approaches to assessing for malingering beyond the clinical interview. One of the most frequently utilized measures in personal injury evaluations is the MMPI or MMPI-2 (Lees-Haley, 1992). In terms of scope of practice, the MMPI-2 is identified as acceptable to use in assessing malingering by more experts (92%) than any other measure and is recommended by 64% of experts in cases where malingering is suspected, closely followed by the Structured Interview of

Reported Symptoms (SIRS; 58%) discussed in Chapter 2 (Lally, 2003). In addition to the clinical scales assessing for a variety of mental illnesses, the MMPI-2 also contains several scales designed to assess for unusual response styles such as exaggeration and defensiveness.

Studies examining the effectiveness of these scales have taken some interesting approaches. Cramer (1995) asked college students to read information about specific mental illnesses (e.g., depression and paranoid schizophrenia) and then take the MMPI-2. These students were able to more accurately fake symptoms of the disorder than those students not given any additional information about the specific disorders. However, Cramer (1995) could tell the informed fakers and the uninformed fakers from individuals actually suffering from the depression and paranoid schizophrenia. These results have been replicated for other disorders and when financial incentives were offered to produce valid results for these disorders, as many as 95% of the malingerers were detected (Wetter, Baer, Berry, Robison, & Sumpter, 1993). Research also has suggested that several MMPI-2 scales may be able to identify individuals who attempt to fake head injuries (Berry & Butcher, 1998). MMPI-2 results for individuals involved in litigation are generally more exaggerated and suggest more mental illness than individuals not involved in litigation. However, these scales are not without limitations and forensic psychologists need to be aware of them when conducting personal injury evaluations (Butcher & Miller, 2006).

Typical Injuries Involved in Personal Injury Claims

There are a variety of different injuries exhibited by personal injury claimants that forensic psychologists may evaluate. This section will discuss three of the most prominent: posttraumatic stress disorder (PTSD), neuropsychological damage, and chronic pain. However, there are a variety of different psychologically related illnesses that someone may suffer in these situations. Generally, there are three broad areas of injuries that the courts will compensate plaintiffs for under tort law. Historically, courts were first likely to compensate victims who suffered physical injuries that led to psychological injuries. Courts probably had the easiest time compensating victims in these types of cases because the causal path was more easily identified and seemed more legitimate in the eyes of the courts because the physical injury legitimized the psychological injury (Melton et al., 2007). An example of this type of injury would be if someone were mugged and in the process sustained a head injury. The head injury may lead to poor attention, a lack of concentration, some memory impairment, or even personality change.

Cases in which an individual suffers only a psychological injury are much more demanding. Although these instances have become much more common, being compensated for strictly psychological injuries is difficult (McLearen et al., 2003). The courts are more suspicious of these types of injuries because they believe there is often a lack of concrete evidence for the injury compared to a physical injury. One of the earliest cases in which psychological injuries were seen as compensable occurred in 1348.

In this case, a guest at an inn threw a hatchet at the innkeeper's wife, but she avoided it and did not suffer any physical injuries. The innkeeper brought suit for mental pain and suffering and was awarded damages for his wife (Mendelson, 1995). Though strict psychological injury claims are difficult to prove in court, PTSD is becoming a common basis for injury in these cases, as we will discuss later in this chapter.

The third and final general type of injury that is compensable is the worsening of a preexisting psychological condition. A person with preexisting episodes of major depression could claim that the mugging she suffered increased the severity of the disorder and caused her to seek additional treatment. In these instances, it is important to have a clear idea of the person's baseline or premorbid functioning prior to the incident and an identified period of stability. The difficulties involved in these types of cases should be clear. Not only does the plaintiff have to prove the existence of a psychological illness or injury but the plaintiff must prove that it has become worse since the specific event in question. Unfortunately, there is no significant evidence that psychologists are successful at detecting the precise causes of psychological injuries or that a given psychological injury has worsened because of a recent trauma compared to past traumas (Koch, Nader, & Haring, 2009), questions often at the very heart of the legal question in personal injury cases.

Posttraumatic Stress Disorder (PTSD)

PTSD probably represents the single largest psychological disorder for plaintiffs in personal injury cases and may have a greater impact on the court system than any other mental illness in history (Stone, 1993). As suggested before, there is probably a reason for the increasing reliance on PTSD in personal injury litigation. PTSD provides a way for a plaintiff to make her emotional suffering more tangible by having it supported by the presence of a psychological disorder. However, major depression and many other anxiety disorders also provide more tangible anchors than general emotional pain and suffering. Is there something else about PTSD? Yes. PTSD is the only mental illness that, as part of its diagnostic criteria, necessitates a specific triggering event for the disorder to be diagnosed. This causal relationship, whether any different than most psychological disorders or not in reality, provides a more clear causal relationship for the courts. Given that a specific event must be the proximate cause of the psychological injuries, the courts look favorably on this type of causal pathway. Moreover, the literature is taking note and examining the issues relevant in these forensic circumstances (Wald & Taylor, 2009).

In addition to the presence of a traumatic event, referred to as Criterion A (i.e., presence of a trauma) in the diagnostic criteria of DSM, there are three additional major symptom groups for PTSD (APA, 2000). In order to be diagnosed with PTSD, a person must present symptoms from Criteria A, B, C, and D for at least a month. If symptoms are present for 2 days to 4 weeks, the person can be diagnosed with another mental illness, acute stress disorder. Criterion B consists of different reexperiencing symptoms such as upsetting memories of the event, distressing dreams, and flashbacks. Criterion C is the avoidance cluster of symptoms and includes symptoms like trying to avoid

thoughts, feelings, places, or people associated with the trauma and the inability to recall certain important information about the trauma. The final group of symptoms, Criterion D, focuses on increased arousal such as sleep disturbances, a heightened startle response, or excessive vigilance to the surrounding environment. Two people with PTSD may not share identical symptoms, but all those diagnosed must experience a traumatic event meeting Criterion A and experience, one, three, and two symptoms from Criteria B, C, and D, respectively.

Experiencing many of these symptoms is quite normal for someone who has experienced a traumatic or extremely anxiety-provoking situation. For example, many people are involved in a car accident at some point in their lifetime. If you or someone you know was, did you experience any of these symptoms afterward? Did you avoid driving after the accident? Were you extra cautious or vigilant when you were driving, stopping at stop signs, or crossing intersections? Were you startled when you heard some tires screeching? Although these types of reactions are quite normal after a car accident, to be diagnosed with PTSD a particular number of these symptoms must last for 1 month and are considered chronic PTSD if they last for at least 3 months (APA, 2000).

The only problem from a legal standpoint is that PTSD is increasingly seen as having multiple causes. Originally, it was believed that people would develop PTSD as a result of exposure to a traumatic event, originally deemed to be "outside the normal range of human experience" when first identified in DSM-III (APA, 1980, p. 238). Now the event must "involve intense fear, helplessness, or horror" and the person must be "confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (APA, 2000, p. 467). It was the exposure to the traumatic event that was believed to be the cause or the single most important cause of PTSD.

Evolving research has now suggested that there are a range of factors outside of the original trauma including events pre-trauma and post-trauma that contribute to the development of PTSD (Young & Yehuda, 2005). Factors prior to the trauma such as a history of other mental illness and particular personality patterns related to negative emotion or excessive anxiety (Blanchard et al., 1996; Mason, Turpin, Woods, Wardope, & Rowlands, 2006) increase the likelihood that someone exposed to a traumatic event will develop PTSD. Other post-trauma factors such as fear of dying in the situation, additional psychosocial stressors, loss of social support, the pursuit of litigation, and presence of appropriate therapy relate to the development of PTSD (Blanchard et al., 1996; Mason et al., 2006; Young & Yehuda, 2005). As many as 70% of people who experience a traumatic event that would qualify under Criterion A do not develop PTSD. This multicausal conceptualization of PTSD may limit its future use in court or open it up to criticism in a legal context. Courts believe that a forensic psychologist can easily differentiate the factors that occurred before the trauma from the trauma and the events that occurred afterward, but this process often proves extremely difficult (Young & Yehuda, 2005). However, in the future courts may find the evolving research supporting neurobiological markers and characteristic physiological responses for individuals with PTSD as more tangible for legal purposes and once again make PTSD a more acceptable justification for emotional pain and suffering from a legal perspective (Mendelson, 1995).

Forensic psychologists assessing PTSD in personal injury cases have a variety of established measures at their disposal but should be cautious assessing PTSD in the litigation context. The current gold standard for the assessment of PTSD may be the Clinician Administered PTSD Scale (CAPS). Research indicates that it is a reliable and valid tool for the assessment of PTSD (Koch, O'Neil, & Douglas, 2005). In addition to assessing the specific symptoms in Criteria B, C, and D, a forensic psychologist must establish that the trauma meets Criterion A. Currently, there is no psychological measure that can definitively assess whether PTSD was caused by a specific traumatic event (Greenberg, Otto, & Long, 2003; Koch et al., 2009). A forensic psychologist can therefore either take an objective approach and focus on the severity of the physical injury or the resulting personal property damage (Malmquist, 1996) or undertake a more comprehensive view that may include some subjective indications (Koch et al., 2005).

However, courts may be weary of considering the client's subjective responses even though it does not appear to increase the prevalence of PTSD dramatically (see Koch et al., 2005). In addition, assessments of PTSD Criterion A require a thorough examination of past traumatic events, which increases the likelihood of suffering from PTSD. Given that the majority of people experience a traumatic event in their lifetime, it is important for the examiner to also screen for past trauma exposure in order to meet tort elements. Plaintiffs suffering from PTSD also are more likely to recall more symptoms than originally reported. Harvey and Bryant (2000) interviewed accident victims 1 month and 2 years after their accidents. Individuals who were experiencing more severe PTSD symptoms after 2 years recalled suffering from more symptoms 2 years later than they originally recalled at 1 month post-accident. Individuals experiencing no symptoms 2 years post-accident actually now underreported the trauma symptoms they originally reported at 1 month.

Traumatic Brain Injury (TBI)

In addition to PTSD, a significant number of personal injury litigants may suffer from a head injury or traumatic brain injury (TBI). The growth of these types of evaluations is clear by noting that prior to 1980, neuropsychologists were rarely ever involved in the legal system, but today most neuropsychologists are involved in forensic assessments because of their evaluation of individuals presenting with TBIs (Barth, Ruff, Espe-Pfeifer, 2005; Taylor, 1999). The severity of a TBI is usually associated with the length of time the person is unconscious, the extensiveness of any associated amnesia, and the presence of a penetrating injury to the skull. Mild TBIs are usually characterized by less than 30 minutes of unconsciousness and a lack of serious injury to the exterior of the skull. The Glasgow Coma Scale (GCS) is an observational scale used as a brief assessment of head injuries. The scale is used to assess general consciousness and involves an assessment of the injury victim's motor and verbal abilities with scores ranging from 3 to 15. Scores of 3 to 8 indicate a severe TBI, 9 to 12 indicate a moderate TBI, and 13 to 15 indicate a mild TBI (Barth et al., 2005). However, there is confusion and disagreement about specific definitions for different severity levels of TBIs that can make diagnosis difficult (Barth et al., 2005).

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Figure 13.1. Motor vehicle accidents are a significant source of personal injury claims and the most prevalent cause of PTSD and mild TBIs.

The Centers for Disease Control and Prevention estimate that 1.5 million people annually suffer from TBIs and that 75% of these people suffer mild TBIs (mTBI) in a variety of different ways (as cited in Barth et al., 2005). The most common cause of mTBIs are motor vehicle accidents (42%), falls (24%), assaults with a firearm (14%), and concussions due to sports-related activities (12%) (Parker, 2001) (see Figure 13.1). However, only a minority of victims (15%) continue to experience symptoms for longer than 1 year (Guerrero, Thurman, & Sniezek, 2000).

Neuropsychological evaluations of TBIs present many difficult tasks. It is difficult to assess the premorbid level of functioning in neuropsychology cases, outside of prior testing. Courts commonly rely on forensic psychologists practicing neuropsychology to apply their test results to the real world, especially in regard to future functioning. This task can prove difficult because the examiner must generalize from the results of tests administered under very precise and constant conditions to real-world environments that are anything but constant and controlled (McLearen et al., 2003). For example, I once had a client who did not exhibit any significant memory deficits on a host of neuropsychological measures. This same client would genuinely have difficulty finding her way home and had forgotten her son on top of her car, only to realize it when her husband came home later and noticed the infant in his car seat on top of the car. Finally, as with other injuries in personal injury cases, it is often very difficult to differentiate brain injuries from attempts to fake or feign the condition, especially when the TBI is

fairly minor (Ackerman, 1999). Compound this general trend with the fact that it is not unusual to identify neuropsychological damage, even in individuals who are malingering or for normals trying to look identical to brain-injured individuals (Millis & Putnam, 1996). One survey of neuropsychologists revealed indications of malingering in 29% of their personal injury referrals and that an identical percentage of individuals claiming mild head injuries exhibited indications of probable malingering (Mittenberg, Patton, Canyock, & Condit, 2002).

Despite neuropsychological disorders' "objectivity" as a physically based injury and continued admissibility in courts (Stern, 2001, p. 93), forensic psychologists assessing neuropsychological disorders must go to great effort to assess for malingering in all aspects of their evaluation. Intelligence tests are commonly used in these assessments. In fact, Lees-Haley, Smith, Williams, and Dunn (1996) found that neuropsychologists used them in 76% of all their forensic evaluations. Fortunately, it is relatively difficult to malinger on intelligence tests without being detected. Attempted malingerers normally provide inconsistent responses on the different subscales and are unsophisticated in many of their responses (Ackerman, 1999). Memory tasks are slightly different in that it is relatively easy for plaintiffs to malinger impairment on these tasks such as the Wechsler Memory Scale (WMS) and the Wechsler Memory Scale-Revised (WMS-R), but there are certain indications that differentiate malingerers from genuinely brain-injured plaintiffs (Mittenberg, Tremont, & Rayls, 1996). There are also specifically designed tests to assess malingering in neuropsychological evaluations such as Rey's 15-item Visual Memory Test for the Detection of Malingering and the Test of Memory Malingering (TOMM). In addition, many neuropsychological tests are forced choice tests where even chance responding would result in 50% correct, while malingerers frequently fall below chance in an attempt to look impaired.

There is significant controversy in the field of neuropsychology that directly impacts forensic practice. In general, there are two broad approaches to neuropsychological assessment. A neuropsychologist may either take the **fixed battery approach** or the **flexible process approach**. The fixed battery approach necessitates that the examiner administer a standardized set of neuropsychological tests in an identical manner to gain a comprehensive picture of the client. The fixed battery approach may sometimes mean that some of the tests are not directly relevant to the potential impairment and therefore administration time can be extensive. The fixed battery approach is the more traditional approach to administer neuropsychological tests and much of the empirical support behind different neuropsychological tasks is based on this approach. In the flexible process approach, an examiner is more selective about the specific tasks she asks of the examinee and usually selects tests that assess only those areas for which the symptoms suggest possible impairment. This approach is more directed and generally takes less time to administer. The controversy arises because many of the neuropsychological tests have not been empirically tested outside of their original battery and the examiner may miss indications of impairment that do not fall within their more limited parameters, as created by the selected number of tests. A legal issue arises because the flexible approach has been criticized, at times successfully, for not fulfilling the scientific admissibility criteria of *Daubert* (Chapter 3) or even just the general acceptance criteria. However,

there also are instances in which the flexible battery approach has been admitted because it was generally accepted or met the *Daubert* requirements. The results of Lees-Haley et al. (1996) research seem to suggest that both approaches are generally widespread among neuropsychologists in forensic evaluations.

Chronic Pain

The final area in which personal injury claims and forensic psychology overlap is with the assessment of chronic pain. At first glance, it may seem that forensic psychologists would not have anything to do with evaluating someone for the degree of pain he is experiencing. Many people associate pain with a clear physical basis and assume that a physician would be solely responsible for assessing a patient's pain. However, the overwhelming majority of the time there is no objective test for the severity of pain a person is experiencing. Furthermore, pain is very much a psychological experience with people experiencing it differently, depending on a host of psychological variables, despite similar physical injuries.

There is an extensive history examining the role of psychological factors in the subjective experience of pain (Gatchel & Kishino, 2005). Further, there are long-established correlations between personality and pain. Individuals who suffer from chronic pain are at greater risk for suicide, depression, anxiety, and substance abuse (Dersh, Polatin, & Gatchel, 2002) and chronic pain has been identified as one of the top health concerns by the Surgeon General (Hanscom & Jex, 2001). The belief of a specific personality type that is more susceptible to report chronic pain is largely outdated (Gatchel & Kishino, 2005). Though personality disorders are more common in chronic pain sufferers, there is little consistency regarding the specific personality disorder that is more likely in individuals who experience chronic pain (Gatchel & Kishino, 2005). Research also suggests there are a variety of cognitive factors that relate to the reporting of pain (Pincus, 2005). There appears to be good support for the role of locus of control, cognitive distortions such as catastrophizing, attention, avoidance of fear, and overall coping strategies in the pain experience (Linton, Vlaeyen, & Ostelo, 2002). For example, professionals have begun to recognize a difference between people who exhibit an active coping response and people who exhibit a passive coping response. Individuals who cope passively report greater pain (Pincus, 2005). Finally, return to work is often used as a sort of gold standard in chronic pain cases. Research suggests that psychosocial variables account for more of the reason for an individual returning to work than do physical symptoms (Gallagher et al., 1989).

The role of the forensic psychologist in regard to assessing and treating chronic pain is a difficult one. The forensic psychologist must be aware of the different psychological variables related to chronic pain but also be aware they may contribute to the pain experience or be a result of the person experiencing severe and chronic pain. For example, an individual may be more prone to experiencing chronic pain because of a personality style or may develop a certain personality style (e.g., depression) because the person has to live with a chronic disability. Gatchel and Weisberg (2000) recommend a stepwise approach in the assessment of chronic pain whereby clinicians begin

with a global examination of the individual and progressively become more specific in the psychological factor they are assessing. Although there are a variety of personality measures such as the MMPI-2, Beck Depression Inventory, or the Symptom Checklist-90-Revised that are very appropriate for assessing personality in chronic pain patients, there are very few standardized measures for assessing the relevant cognitive factors (Pincus, 2005). Nonetheless, these data continue to be used to determine the person's potential for rehabilitation, which would factor directly into any compensation being sought (for example, lost wages, cost of therapy) and the extensiveness of any pain and suffering.

In addition to assessing for the psychological and cognitive dimensions that may be related to the pain experience, forensic psychologists should also assess for motivation (Gatchel & Kishino, 2005). People experiencing chronic pain often limit their activity to avoid experiencing the pain. People who become satisfied with these limitations after all medical options have been exhausted are poor candidates for a pain management program that can assist them in overcoming the limitations they may associate with their pain (Gatchel & Kishino, 2005). Besides general motivation to cope with the pain, there may be additional secondary gains associated with maintenance of the pain experience.

As with TBIs, there is evidence of a link between compensation for chronic pain and reports of chronic pain. A meta-analysis of the available studies focusing on chronic pain indicated that individuals who seek compensation report greater pain and are less likely to benefit from treatment (Rohling et al., 1995). Moreover, there has been a dramatic increase in the number of individuals seeking compensation for chronic pain. One study found almost a 2,700% increase in financial expenditures related to one chronic pain injury, lower back injuries, while the incidence of lower back pain remained constant (Fordyce, 1985). In fact, only one-quarter of all disability claims involve lower back pain, but they still account for a majority of the compensation doled out for disability claims (Spengler et al., 1986).

As a result, it is extremely important to assess for malingering in chronic pain evaluations. Although there are measures to assess perceptions of chronic pain directly, many forensic psychologists assess the accompanying personality characteristics or additional neuropsychological symptoms for malingering. The MMPI-2 continues to be one of the more common methods used to assess malingering as well as be incorporated into chronic pain evaluations. There appear to be consistent differences on the MMPI-2 between individuals who are experiencing chronic pain and are seeking financial compensation and those who are not seeking compensation. Dush, Simons, Platt, Nation, and Ayres (1994) found that individuals seeking compensation through the courts were more likely to endorse obvious symptoms and less likely to endorse positive symptoms on the MMPI-2. In another study assessing neuropsychological symptoms among individuals with chronic pain, 29% of the individuals seeking compensation failed two or more validity checks in a series of neuropsychological tests, whereas none of the individuals failing to seek compensation failed two or more of those same validity checks (Meyers & Diep, 2000). Failing the validity checks on an instrument like the MMPI-2 suggests the person is giving distorted responses or potentially malingering. Forensic

psychologists evaluating individuals who suffer from chronic pain therefore must be aware of the different response styles to personality and neuropsychological measures and the increased likelihood of malingering in these situations.

Psychological Independent Medical Evaluation

Although the majority of this chapter so far has focused on issues related to personal injury claims generally, there are also specific types of forensic assessments that occur in the civil context. Independent Medical Evaluations (IMEs) are evaluations that take place at the request of insurance companies in ongoing disability claims. Insurance companies may insure a particular individual and need an independent evaluation of the person's disability that prevents the person from working. These evaluations are very similar to personal injury evaluations except that they do not necessitate an evaluation of proximate cause. Although it may be appropriate to examine the underlying cause and circumstances, the forensic psychologist does not need to form an opinion as to whether the original circumstances were the proximate cause of any disability. Instead the forensic psychologist only needs to assess the ongoing symptoms and treatment effectiveness in relation to the person's ability to function in his or her place of employment (Vore, 2007).

Though psychological IMEs are similar to personal injury evaluations, there are significant differences from a legal standpoint. A basic issue in psychological IMEs is the definition of a disability that is preventing the person from working. A disability can be factual, social, or legal. A **factual disability** meets the criteria for a disability as stated in the insurance contract such as an illness or injury that prevents a person from carrying out their job or any job. A **social disability** usually refers to something that is not covered by the specific language of a contract. For example, a physician may contract a communicable disease that prevents her from performing as a surgeon. A **legal disability** usually refers to someone who is unable to work because of a license revocation or suspension. In general, these disability claims may relate to a specific occupation or any occupation and present an important consideration for a forensic examiner. The referral question may be whether the insured person is unable to work in his or her particular occupation because of a psychological injury or unable to work in any occupation. For example, it would be understandable if a lion tamer in a circus was unable to continue his job as a lion tamer after he was mauled by a lion. If his policy provided for compensation while he was unable to continue in his specific occupation, then he may be eligible for continued benefits. However, if the policy required that he be unable to perform in any occupation, the forensic psychologist would have to consider whether a particular psychological injury prevented him from working with the monkeys, operating a cotton candy machine, or doing something totally unrelated to circus performing.

Overall, many of the same legal and clinical practice issues pertinent to forensic work in general pertain to psychological IMEs. Vore (2007) suggests that forensic psychologists performing psychological IMEs should follow the factors relevant to any forensic

evaluation. These steps include conducting a thorough evaluation, identification of any specific deficits that would impair the ability of the insured to perform their job (not assessment of the legal issues related to the presence of a disability), base any opinion on clearly delineated objective data, and finally assess for the presence of distortion or malingering. As with all personal injury–related claims, malingering or exaggeration is an especially important consideration (Richman et al., 2006). Forensic psychologists conducting psychological IMEs also should be mindful of additional legal and ethical issues relevant to forensic evaluations such as avoidance of dual relationships, identification of the client (i.e., the insurance company), informed consent, and scope of practice issues (Evans, 1992). In these instances, the law is increasingly scrutinizing the independent nature of these evaluations in order to avoid conflicts of interest that may arise from psychologists attempting to appear independent but actually working as default representatives of the insurance companies. Their intent was to provide a more therapeutic outcome by providing truly independent examinations.

Workers' Compensation

Another area of forensic practice that is related to personal injury is workers' compensation. Workers' compensation laws were intended to compensate employees who have been injured while performing work-related responsibilities. Employers purchase insurance to provide this benefit and employers are compensated for their injuries, regardless of whether the employee or the employer is at fault (Charlton, Fowler, & Ivandick, 2006). Before workers' compensation laws, employees who were injured on the job could only be compensated via personal injury claims as a matter of tort law. As a result, employers had a number of potential legal defenses in line with the tort law previously discussed (Melton et al., 2007). Workers' compensation laws were developed to reduce the difficulty employees had in receiving compensation for viable injuries suffered on the job, because many saw the past system as a failure or anti-therapeutic.

However, in streamlining the personal injury process both parties relinquished certain legal rights they normally held. Employers cannot present many of the legal defenses that would have been available to them under tort law. The employees are not able to pursue the unlimited compensation that may arise from a personal injury lawsuit. Though the employers and employees must relinquish certain rights, the process has had an overall therapeutic impact (Lippel, 1999). Employees gave up the right for potentially unlimited compensation and instead received a greater likelihood of compensation and a fixed plan of compensation. Another interesting aspect of workers' compensation claims is that they are not designed to make the employee whole as are traditional compensatory damages in civil law. Workers' compensation is intended to replace lost earnings and pay for any additional expenses that may be incurred as a result of the work-related injury.

For the forensic psychologist, the process does not change a great deal. Employees seeking workers' compensation can suffer any of the same injuries suffered under personal injury claims. An employee could be making a delivery and be involved in an

Box 13.2. Focus on Research: The Emerging Role of Psychological Evaluations in Combat Veterans

Although it does not fall under the umbrella of worker's compensation, the increasing prevalence of PTSD among veterans of the War in Iraq is related to our discussion of these claims. However, instead of falling under workers' compensation, veterans claiming PTSD are seeking to access disability benefits provided through their military benefits and military regulations. Moreover, these evaluations and the reception of these benefits are receiving increasing attention as veterans return from Iraq with rates of combat-related PTSD that may be two, three, or four times greater than previous combatants, and with as many as 50% of those returning suffering from PTSD symptoms. Although these claims are not routinely handled as worker's compensation claims, they do involve the veteran's psychological evaluations to apply for disability benefits through the military. These disability evaluations resemble the forensic evaluations discussed in this chapter and are similar to another type of forensic evaluation not discussed in this chapter, evaluations for social security benefits. For example, they have specific requirements to meet much like the legal requirements for other civil issues. Military regulations require that the PTSD must not be the result of a preexisting condition, must have been caused by their experiences while in the military, and must result in a disability that prevents future service or reduces ability to work in a civilian occupation. Furthermore, these situations are making headlines as at least one lawsuit has been filed against the Veterans Administration (VA) on behalf of the returning veterans that alleges the VA has failed to give mandatory disability benefits, has failed to address staff problems, and has provided insufficient care for veterans returning with posttraumatic stress disorder. These evaluations are becoming very commonplace and the literature is beginning to address the unique difficulties that arise in this area of forensic practice (Evans, 2011; Worthen & Moering, 2011).

automobile accident in the course of that delivery. He may then develop PTSD (see Box 13.2 for a current issue in the assessment of work-related PTSD) as a result and seek compensation through the workers' compensation program. Another employee working in a warehouse may suffer a lower back injury or fall while stacking material on a shelf and thereby suffer a head injury. In all of these cases, the employee can seek compensation through workers' compensation claims as he or she would have through a much more time-consuming and uncertain personal injury claim. As long as these events result in an injury or disability, occur during the course of employment, and are accidental, then workers' compensation laws are likely in effect (Meriano, 2001). As with all evaluations in which the examinee is seeking financial incentives, the forensic psychologist should make special efforts to assess for malingering or exaggeration of any symptoms in an attempt to receive greater compensation.

Another related area is that of psychological consultative examinations (PCE) for the Social Security Administration (SSA). These evaluations entail verification of a condition for which the examinee is applying for Social Security benefits as one of the

roles of the SSA is to provide in essence disability insurance for individuals unable to work. These bring about the normal issues in related assessments. Forensic psychologists need to be mindful of malingering and of somatoform disorders in making these determinations. However, it is SSA policy not to purchase tests associated with assessing for malingering. The SSA admonishes psychologists for using the term *malingering* as too subjective and the term is not included in major SSA publications for various reasons (Chafetz, 2011). Chafetz (2008) found that 12% to 14% of individuals sitting for these evaluations fell into the definite malingering category with another 22% to 35% providing responses that put them well below chance levels and below what would have been expected in these evaluations except from those severely demented. These evaluations present unique challenges because of the SSA stance on the validity of the different methods routinely used to assess malingering.

Sexual Harassment and Employment Discrimination

A final area of civil law that departs significantly from our previous discussion of traditional personal injury claims is the evaluation of sexual harassment and employment discrimination. Discrimination occurs in the workplace for a variety of reasons, though the Civil Rights Act of 1964 identified gender, race, religion, and national origin as protected classes of people who are legally protected against discrimination. Additional laws have provided protection for other groups of people and other specific legal mechanisms that may need to be addressed in addition to the requirements in the Civil Rights Action of 1964 (Vasquez, Baker, & Shullman, 2003). Furthermore, discrimination and harassment are not a completely independent entity and may arise in the context of workers' compensation and personal injury claims in general.

Discrimination claims either result from discriminatory effects or discriminatory treatment. **Discriminatory effects** require that the plaintiff show an entire group has been negatively impacted by a workplace policy or general practice. **Discriminatory treatment** only requires showing that one person has been harmed. Harassment is a form of discrimination that requires the workplace to have been adversely altered. Sexual harassment is a form of harassment that involves unwanted sexual behaviors. Research has found that roughly 49% of women and 33% of men received some type of unwanted sexual attention (see Douglas & Koch, 2001b). Sexual harassment can include **quid pro quo harassment** in which an employer or supervisor expects the employee to comply with sexual demands or behaviors in order to maintain his or her employment. It can also include hostile work harassment. **Hostile work harassment** applies to cases in which sexual demands or behaviors make the work environment unbearable (Douglas & Koch, 2001b).

The role of a forensic psychologist in discrimination and harassment claims is unique compared to the other areas explored in this chapter. The forensic psychologist is asked to determine whether the harassment or discrimination occurred, why it occurred, and the effects on the defendant (Vasquez et al., 2003). Of course, it is not within the scope of practice of a forensic psychologist to actually determine the

physical occurrence of the discrimination or harassment or why it occurred. However, the forensic psychologist can examine the psychological state of the defendant after the alleged events to determine whether there is any support for the damage the defendant claims. There is also a significant social science literature examining the impact of discrimination and harassment in the workplace that any clinically trained forensic psychologist must consult (Fiske, 1998). For example, a forensic psychologist often must address whether the behavior was unwanted in determining why it occurred. The forensic psychologist should be aware that there is a significant difference in the way men and women generally perceive attention to be unwanted. It is incumbent on the forensic psychologist to be familiar with the psychological literature examining the myriad of individual differences and the impact of various forms of discrimination and harassment. This expertise is usually a new challenge for most forensic psychologists and should not be underestimated when considering whether one is qualified to conduct these types of evaluations. In addition to the unique legal requirements and the accompanying scientific literature, these evaluations involve the same content and procedures discussed throughout this text and this chapter. The examining forensic psychologist should be aware of the general legal difficulties such as identification of the client, the psychological tests that are appropriate and standardized in these situations, and the increased chance of malingering when financial incentives are at issue.

Reflection and Review

1. What are the four elements of a tort?
2. What are the different ways in which forensic psychologist must assess work-related claims?
3. How important is assessing malingering in personal injury claims?
4. What is the difference between discriminatory effects and discriminatory treatment?

Key Terms

assault
battery
compensatory damages
discriminatory effects
discriminatory treatment
factual disability
fixed battery approach
flexible process approach
hostile work harassment
intentional torts
legal disability
negligence
punitive damages
quid pro quo harassment
social disability
strict liability
torts

Further Readings

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Glossary

actuarial risk assessments – approach to violence risk assessment that tends to be fixed and based on a mathematical foundation.

ALI standard – a legal standard for insanity developed by the American Legal Institute that focuses on a person not being criminally responsible if his behavior "is the result of mental disease or defect [and] he lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of the law." It is also referred to as the *Brawner* rule.

amicus curiae – Latin for "friend of the court." It refers to a legal brief written by a neutral party that is intended to aid the court in arriving at a decision.

antisocial personality disorder – a mental illness listed in the DSM that is characterized by antisocial behavior but is distinct from psychopathy.

appeals court – a court whose role is to review the decisions and actions of lower courts.

archival information – information obtained from outside sources such as mental health institutions, prisons, schools, or physicians that is often used to verify psychological testing or firsthand reports in psychological evaluations.

assault – a legal term used in civil law to refer to the threat of violence, whereas battery refers to the perpetration of actual violence. However, assault normally refers to actual violence when used outside of civil law.

automatism – a criminal defense that claims a defendant's actions are automatic or involuntary, such as in the midst of a seizure or during sleep.

base rate – the frequency or prevalence of a particular event, frequently used in the context of violence.

battering – a form of domestic violence often characterized by more severe violence and a tremendous financial and interpersonal control of the victim.

battery – a legal term used in civil law to refer to actual violence, whereas assault refers to the threat of violence.

best interest of the child – the current legal standard used in custody cases in the United States that focuses on awarding custody based on what is best for the child, not the property interests of the parents or other interested parties.

binding – something must be followed legally in a given jurisdiction.

***Brawner* rule** – a legal standard for insanity that focuses on a person not being criminally responsible if their behavior "is the result of mental disease or defect [and] he lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of the law." It is also referred to as the ALI rule.

burden of proof – the duty to establish or prove a legal claim that one side in the matter traditionally must meet over the other side. The prosecution typically has the burden of proving their case against the defendant in criminal trials and the plaintiff has the burden of proving their case in civil matters.

case law – law created by the opinions of judges based on rulings from appellate courts. It is in contrast to statutory law that is created by legislatures.

character evidence – testimony used to describe a person's general character and reputation in the community. It is in contrast to substantive evidence that is used to prove a fact at issue in a trial.

chattel – another name for personal property.

child molester – a person who sexually assaults a child.

circuit court – first level of trial courts in the state court system.

civil law – law that focuses on disputes between two individuals as opposed to criminal law, which focuses on disputes between an individual and society. Civil disputes usually involve personal injury or property damage.

clinical psychology – a branch of psychology focusing on the assessment and treatment of mental illness.

clinical risk assessments – a form of violence risk assessment where the decision is based on the education and experience of the evaluator and is made without the assistance of any additional formal actuarial or structured assessment tools.

clinical sample – used in psychological research to refer to a group of people seeking assistance for psychological or emotional difficulties.

coercion – refers to the act of compelling a person by force or authority to participate in mental health treatment.

cognitive distortions – a term used to describe faulty cognitions or thoughts often present in individuals with mental illness.

common law – law based on custom and traditions present in many countries that were previously colonies of Great Britain.

community sample – used in psychological research to refer to a group of people from the general community that are not targeted because they are seeking assistance for mental health issues.

compensatory damages – financial damages awarded in civil trials that are intended to compensate the defendant for any injuries suffered.

competency restoration – the process of restoring the defendant to a level of mental functioning that enables him or her to participate adequately in the legal process.

conditional release – a form of outpatient commitment that involves a person agreeing to participate in treatment as an outpatient after her inpatient commitment. If she fails to comply with the conditions of the release, she is returned to the hospital as an inpatient.

contingency fee – an agreement by which a professional, normally an attorney, receives a fee based on the outcome. For example, attorneys routinely receive a percentage of any damages recovered in a civil lawsuit but receive nothing if they are not victorious in court.

correctional psychology – branch of clinical psychology that focuses on the application of clinical psychology to individuals incarcerated in jails and prisons.

criminal law – law that focuses on disputes between individuals and society in general. The state or government is the representative of society in criminal law and brings charges against an individual for violating it.

criminal profiling – the process by which characteristics of a crime and crime scene are collected and systematically organized to narrow down the potential suspects.

criminogenic needs – the goals that offenders have or the needs they fulfill when committing crimes.

deinstitutionalization – a process involving release of the mentally ill from psychiatric facilities and encouraging them to integrate into the community.

desistors – individuals who have committed juvenile crimes but discontinued their criminal pattern as adults.

diminished capacity – a legal defense that reduces or eliminates the criminal responsibility of a defendant because of a diminished mental state when a particular mental state is required for commission of a crime.

discriminatory effects – a requirement in discrimination claims that the plaintiff show an entire group has been negatively impacted by a workplace policy or general practice.

discriminatory treatment – a requirement in discrimination law that the plaintiff show that a person has been harmed by discriminatory practices.

district courts – trial courts in the United States federal court system.

divided custody – form of custody where each parent is awarded sole custody during different parts of the year.

due process – a guarantee that the judicial process will be fair and the trial impartial.

Durham rule – standard for insanity that considers if the crime is a product of mental disease in the defendant. It is also called the product rule.

dynamic factors – risk factors that normally change over the course of time and are more likely to be amenable to treatment or intervention to reduce risk.

emergency commitment – a form of civil commitment where a person can be held for a brief period of time, normally 24 to 48 hours, with few due process protections or the formalities involved in extended commitments.

exhibitionist – a person who suffers from a paraphilia characterized by receiving sexual gratification from exposing one's genitals to others.

extended commitment – a form of civil commitment in which an individual is held for an extended period of time in a psychiatric facility with regular review of his or her status to assess his or her mental health and dangerousness.

extrafamilial child molester – a person who sexually assaults a child who is not related to the molester.

fact witness – a witness who has direct knowledge of the events at dispute in a case. A fact witness is often referred to as simply a witness or an eyewitness if he or she actually saw the events in dispute.

factual disability – a legal disability that meets the criteria for a disability as stated in the insurance contract such as an illness or injury that prevents a person from carrying out their job or any job.

femicide – the murder of someone who is a woman.

fitness – a term synonymous with competence, commonly used in Canadian law.

fixed battery approach – an approach to conducting neuropsychological assessments in which an examiner administers a standardized set of neuropsychological tests in an identical manner to gain a comprehensive picture of the client.

flexible process approach – an approach to conducting neuropsychological assessments in which an examiner administers unrelated tests that target specific neuropsychological deficits.

forensic assessment instruments – psychological measures intended for use in forensic contexts.

forensic psychology – a branch of psychology characterized as the intersection between the law and clinical psychology by which psychologists attempt to assist the courts in order to resolve legal issues.

forensically relevant instrument – psychological measures that focus on clinical issues, which are more common in the legal system, such as psychopathy or future violence, but that have not been designed specifically to be used in the legal system.

frotteurists – individuals who suffer from a paraphilia characterized by rubbing one's genitals on unsuspecting individuals in public places.

functional abilities – abilities that impact a person's functioning within the legal context and interact with the legal process itself.

grave disability – one of the requirements for civil commitment in some jurisdictions or a component of danger to self in other jurisdictions that is characterized by an inability to care for basic needs such as food, shelter, and safety.

hired gun – a negative term used to describe an expert witness who testifies for a particular side in a trial and who may be willing to testify to anything that side wishes as a result of being paid for the work.

hostile work harassment – sexual harassment in which sexual demands or behaviors make the work environment unbearable.

idiographic – concerns the study of specific unique events or individuals and normally is used in the context of violence risk assessment.

in absentia – a Latin phrase meaning "in absence" and used to indicate the legal prohibition of an individual being absent from certain legal proceedings.

instrumental violence – violence committed with a purpose or in a planned or organized manner.

intentional torts – a category of torts that indicates an intentional or purposeful act is required for liability such as in cases of assault and battery.

intergenerational transmission of violence – the finding in psychology that victims of violence in one generation (children of violent parents) are more likely to perpetrate violence against the following generation (their own children).

intoxication – a legal defense that claims a person's normal capacity is inhibited by the consumption of alcohol or drugs.

intrafamilial child molester – a person who sexually assaults a child who is related to the molester, or who is a member of the molester's family.

irresistible impulse test – a legal requirement for insanity often added to the *M'Naghten* standard that

requires that a defendant be found insane if his or her behavior was the result of an impulse that the defendant could not control.

joint custody – form of custody where parents share custody of a child or children and both have ongoing responsibility for their care.

joint-degree program – a type of graduate program in which the student earns both a degree in psychology and one in law simultaneously.

junk science – a term used in legal rulings to refer to expert testimony based on poor or unsubstantiated findings.

jurisdiction – the power of the court to rule in a matter in a particular geographic region such as a county or state.

juvenile delinquency – behavior that is a violation of criminal law, but that is committed by individuals who have not yet become adults.

legal custody – a form of custody that allows the custodian to make legal decisions regarding a child, such as for medical treatment.

legal disability – a disability that prevents someone from working because of a license revocation or suspension.

mandatory arrests – a practice requiring law enforcement officials to arrest someone when it is clear that domestic violence has occurred, despite the wishes of the parties involved.

mediation – a legal process by which disputes are resolved through negotiation by a neutral authority figure and not settled in court.

mens rea – a Latin phrase meaning "guilty mind" that is used to indicate intent to commit a crime. The presence of mens rea is a requirement for guilt in many crimes.

meta-analysis – a statistical technique that allows for the quantitative combination of data from numerous studies.

***M'Naghten* standard** – insanity standard that applies if the defendant suffers from a defect of reason, from disease of the mind, as not to know the nature and quality of the act or did know he was doing wrong. It is the most frequently used standard in the United States.

negligence – a type of tort in which a person does not act as a reasonable person would under certain circumstances.

nomothetic – refers to the study of universal or general scientific laws that are applicable to groups of people. The term is frequently used in violence risk assessment to contrast with idiographic decisions made about individuals.

objective test – a personality tests in which an individual is asked a question and expected to respond in a structured and direct manner such as on a rating scale or a true-false format.

paraphilia – a broad class of mental illnesses characterized by abnormal sexual thoughts, urges, and behaviors.

paraphilia NOS – a type of paraphilia that does not fall under the specific diagnostic requirements of any other subtype of paraphilia, but that is a sexual disorder nonetheless, a paraphilia not otherwise specified.

parens patriae – a Latin phrase meaning "parents of the nation" that is the basis of a legal doctrine that encourages the state to act as a parent to anyone in need of protection.

passive avoidance learning – a learning deficit that makes it less likely that psychopaths will inhibit behavior in order to avoid punishment.

pedophile – a person who suffers from a subtype of paraphilia in which the individual reports thoughts, urges, or behaviors indicating sexual attraction toward prepubescent children.

penile plethysmograph – a phallometric method of assessment in sexual offenders that consists of assessing the individual's arousal to sexual stimuli through physiological devices.

persistors – individuals who have committed juvenile crimes and continue their criminal pattern as adults.

physical custody – custody based on the parent the children live with and who is primarily responsible for their daily care. Custodial arrangements such as sole custody and joint custody normally refer to the physical custody of the child, not the legal custody.

police power – a legal doctrine that empowers the state to act in a way that is necessary to protect the general welfare of society.

policy evaluator – psychologists who use their training in research methodology to assess the effectiveness of government policies, regulations, and laws.

posttraumatic stress disorder (PTSD) – an anxiety disorder precipitated by a traumatic event that leads to symptoms involving reexperiencing the event,

avoidance of event-related stimuli, and increased arousal.

prejudicial – causing harm or injury, normally used in the context of the prohibition of evidence that is more prejudicial than probative.

preventative commitment – a form of civil commitment in which an individual does not meet the legal requirements for civil commitment but he or she is expected to deteriorate in the future to such an extent as to meet the requirement.

primary psychopathy – a subtype of psychopathy in which the individual is free from anxiety and best represents a true psychopath.

probative value – helping to prove a particular point, used in the context of the prohibition of the admission of evidence that is more prejudicial than probative.

procedural justice – a notion that focuses on the process by which decisions are made instead of the outcome of those decisions.

product rule – standard for insanity that considers if the crime is a product of mental disease in the defendant. It is also called the *Durham* rule.

projective test – a personality test that involves the presentation of ambiguous stimuli.

protective factors – characteristics that reduce the likelihood of someone committing violence or other crimes in the future.

protective order – any order issued by a court meant to protect a person from harm or harassment.

psychopathy – a clinical construct characterized by deficits in interpersonal and emotional functioning that increase the likelihood of the individual behaving in an antisocial manner.

punitive damages – damages awarded in a civil trial in excess of compensatory damages that are intended to punish plaintiffs for their behavior.

quid pro quo harassment – sexual harassment in which an employer or supervisor expects the employee to comply with sexual demands or behaviors in order to maintain his or her employment.

reactive violence – a form of violence that occurs out of emotion such as anger or fear.

relapse prevention – a form of treatment used with sexual offenders in which the individual is taught to identify situations in which relapse or the commission of a sexual crime is likely to take place in order to avoid those situations.

reliability – a scientific term related to consistency and stability of measurement.

responsivity – the idea that any treatment should match the needs of the individual being treated and be specifically tailored to him or her in order to increase the likelihood of effectiveness.

restraining order – a legal order granted by a judge forbidding a party from doing something, normally preventing contact between two parties in the context of a domestically violent relationship, that may also include other provisions regarding children or joint property.

risk assessment – a psychological assessment designed to identify the likelihood of a person committing violence in the future, along with the severity, imminence, and nature of that violence.

risk management – a form of risk assessment in which the goal is not only to assess the propensity for future violence but also to reduce or manage that propensity so that it does not result in violent behavior.

scope of practice – the parameters of professional expertise in which a psychologist must practice.

secondary gain – any external gain that someone derives from suffering from a mental illness.

secondary psychopathy – a form of psychopathy caused by societal disadvantages, and which includes the occasional expression of anxiety.

semi-structured interview – a type of interview that has a recommended format but does not need to be followed precisely.

sexual predator – a legal term describing a sexual offender who is mentally ill and likely to commit a future sexual crime. As a result, this person is civilly committed after he or she serves his or her original criminal sentence to prevent a future sexual assault.

sham emotions – a characteristic often found in psychopaths in which they mimic emotional expression but do not experience the emotion itself.

social disability – a disability that prevents someone from carrying out his or her employment because it is socially undesirable but is normally not covered by the specific language of a contract and may not disable him or her physically in other ways.

sole custody – a form of custody in which one individual is awarded custody of the children.

specialized forensic instruments – psychological measures directly relevant to a specific legal standard and the abilities that relate to that legal standard.

split custody – a form of custody where the custody of multiple children is split between two parents.

standard of proof – the degree of proof required to prevail in a legal action.

stare decisis – a Latin phrase meaning "let the decision stand" and that is indicative of the tendency for the law to be unwilling to overturn or ignore prior court rulings.

static factors – characteristics used to assess violence risk that are normally inflexible and do not change. Static factors are often called historical factors.

status offense – juvenile offenses that would not be considered a violation of criminal law if committed by an adult.

statutory law – law created by legislative branches of government. It is in contrast to case law that is created by the courts.

strength-based assessment – an approach to assessment that focuses on a person's strengths or positive aspects instead of their deficits or liabilities.

strict liability – a type of tort in which it is not important to prove the conduct was wrong but only to prove that someone was doing something that caused damage.

structured interview – a clinical interview in which the interviewer is required to ask specific questions and follow specific procedures.

structured professional judgment – a form of violence risk assessment in which the individual uses a structured risk assessment tool that provides guidance regarding the risk factors to consider but does not require a definitive decision.

substantive evidence – evidence used to prove an issue before the court. It refers to the typical evidence admitted into a court of law and is in contrast to character evidence that is not directly related to the in-court issue but instead relates to the reputation of a person.

successful psychopaths – a term used to refer to psychopathic individuals who are unlikely to be incarcerated and tend to be more intelligent, come from higher socioeconomic status, and commit white-collar crimes.

syndrome evidence – evidence increasingly being admitted into courts that refers to a set of symptoms occurring together in a meaningful manner and typically having a triggering event.

tender years doctrine – the legal doctrine that indicated a clear preference for awarding custody of children to their mothers because of the developing nature of children and the perception that women were best equipped to nurture them.

testator – the person who makes a will.

therapeutic assessment – a psychological assessment performed to assist in future therapy or improve a person's psychological functioning.

therapeutic jurisprudence – the study of the law and the legal process as an agent to promote therapeutic or positive outcomes and avoid anti-therapeutic outcomes.

threat assessment – a form of risk assessment designed to assess the seriousness of threats to lead to future violence.

torts – a violation of civil law.

traditional outpatient commitment – an alternative to inpatient treatment that requires the person meet the criteria for civil commitment, but committed individuals are allowed to seek treatment on an outpatient basis.

ultimate issue testimony – expert testimony in which the expert gives a conclusion that answers the ultimate legal question, the question that is presently before the court.

unstructured interview – a type of clinical interview in which the interviewer does not follow specific questions or format.

validity – a scientific term related to accuracy of measurement.

voyeurs – individuals who suffer from a paraphilia characterized by receiving sexual gratification from recurrent viewing of sexual acts or the sexual organs of others.

wild beast test – insanity standard defined by a total deprivation of understanding and memory and a lack of knowledge of what he is doing any more than an infant, a brute, or a wild beast.

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